Name_____

Address_____

Pages copied_____

Date_____ **Signature**_____

Name_____

Address_____

Pages copied_____

Date_____ **Signature**_____

The personal information requested on this form is collected under the authority of Section 32 (c) of the Alberta Freedom of Information and Protection of Privacy Act for the purpose of processing your request and copyright. If you have any questions regarding the collection or use of this information, contact the Bruce Peel Special Collections Library, University of Alberta, Tel: (780) 492-5998.

University of Alberta

Library Release Form

Name of Author:	Dawn Kathryn Wrightson
Title of Thesis:	**Community Health Nursing Practice in the Delivery of the Health for Two Program**
Degree:	Master of Science
Year This Degree Granted:	2001

University of Alberta

Community Health Nursing Practice in the Delivery of the Health for Two Program

by

Dawn Kathryn Wrightson

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree Master of Science

Centre for Health Promotion Studies

Edmonton, Alberta

Fall 2001

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **Community Health Nursing Practice in the Delivery of the Health for Two Program** submitted by Dawn Kathryn Wrightson in partial fulfillment of the requirements for the degree of Master of Science.

Abstract

The purpose of this explorative descriptive study was to observe and document the practice of community health nurses delivering the Health for Two program, a prenatal program for disadvantaged women. Program sessions were observed at eleven sites associated with eleven different public health centres and documented using an observation guide. In addition, a self-administered survey was used to collect qualitative and quantitative information from 21 community health nurses. The topics addressed included: issues discussed, goals desired, strategies employed, indicators of success and recommendations for program enhancement. Answers to these questions combined with information gained in the observation sessions provided an impression of the practice. Nurses in this program practice within a framework that considers the determinants of health. Women who participate in this program are affected by poverty and the other health determinants. This influences their ability to have healthy pregnancies and healthy birth outcomes. While nurses are aware of the influences of all health determinants, they act directly to mitigate the effects of some. They assist women to obtain improved access to health services, to improve personal health practices, to identify and enhance social support networks and to stimulate healthy child development. They do this by developing relationships with women in the program, using the resources available at the public health centre and connecting women to other resources in the community.

Table of Contents

Page

Page

Page

List of Tables

Page

List of Figures

Page

Chapter 1

Introduction

1.1 The History and Context of Community Health Nursing Practice in the Delivery of the Health for Two Program

Pregnancy is an excellent time to connect with women. It is a time of physical change and hope when women may be looking to reevaluate their lives and modify health habits such as diet, consumption of alcohol, and smoking (Stotts, DiClemente, Carbonari, & Mullen, 1996). It is a major challenge to reach disadvantaged pregnant women with a relevant program that can assist them to reduce modifiable risk factors (Woodard & Edouard, 1992).

Health for Two is a health promotion program for pregnant women and new mothers living in disadvantaged economic and social conditions. The rationale for the project was the issue of socioeconomic status during pregnancy as a strong predictor of child development in the long term. This collaborative program started in 1992 as a partnership between six inner-city agencies and the Edmonton Board of Health. It was the culmination of discussions that had begun two years previously and part of a broader initiative looking at the issue of food insecurity.

Planning Health for Two engaged natural networks of women who were already present in the participating agencies. These women suggested the need for something concrete to attract pregnant women to this type of service, and milk coupons were introduced as a tangible incentive for women to become involved. Educational material was developed specifically for the target group of women, also with their involvement. Initially, there were 30 women in the program, and it was delivered within the human

resources currently available at the participating agencies. In the public health centres, those human resources consisted of community health nurses.

In 1994 Health Canada announced the Canada Prenatal Nutrition Program (CPNP). Like Health for Two, the program was directed toward low-income pregnant women to provide food, nutritional supplements, nutrition counseling, education support, and counseling on lifestyle issues (Health Canada, 1994). Edmonton was invited to submit a proposal for funding. The health unit was requested to take a lead in establishing a coalition, which included representation from agencies that serve the target population. Edmonton already had that coalition in place and received additional funding to facilitate the ongoing work of Health for Two.

An evaluation completed in 1995 identified that Health for Two had increased links between community-based health and social services agencies. It also identified that the program was reaching women at risk. The risk factors identified among participating women included poor nutrition, substance abuse, poor pregnancy history, poor social support, and low use of the health system. In addition, a large percentage of the women were on social assistance, more than half were of Aboriginal descent, half were under the age of 21, and three quarters had Grade 10 education or less (Capital Health Authority, 1995).

Since its inception, Health for Two has grown and now includes 37 agencies and 12 public health centres, with 50 delivery sites in different neighbourhoods throughout the region. The continued development of this network of agencies has been a key element of the program, which helps to provide a community-based infrastructure to support health. Sword's (1999) review of barriers to prenatal care for low-income women

supported this approach: "Prenatal care, in the broadest sense, encompasses community-based programs which provide support for a healthy lifestyle, foster linkages with health and social services, and add to existing social support networks" (p. 1170).

Health for Two has evolved with respect to delivery methods, as well. Depending upon the resources of the agency and the population with whom they are working, programs are delivered one-on-one or in groups, by appointment, on a drop-in basis, or through home visitation. Program delivery is also strongly influenced by the philosophical foundations and values of the site and the staff working in the program. The program is delivered in sites that vary from a van that provides a needle exchange program (delivered on a harm-reduction model), to public health centres with a more formal clinic environment (and a health-promotion, primary-care model), and a variety of situations in between. The individuals who deliver the program have a range of work experiences, education, and cultural background which allows them to connect with specific client groups. The ability to trust may be a casualty for this group of women clients, and having the service located in a place where they feel comfortable is key to successful relationships being built (Overbo, Ryan, Jackson, & Hutchinson, 1994).

In the public health centres, community health nurses deliver Health for Two. Sometimes they are assisted in the delivery of program groups by other health centre staff and volunteers. The skills and education that nurses bring to the delivery of this program may be different from the background of many of the staff in other community agency delivery sites. In some public health centres increased nursing time has been dedicated to delivery of this program because of the recognition of the excellent opportunity to connect with women. When this has happened, the nurses have requested additional

training in the areas of prenatal health and nutrition. This has not been possible for all nurses delivering the program. One question that needs to be explored is the role of community health nurses in the delivery of Health for Two.

When clients present at a public health centre for a program, they may do so because a nurse is the person they expect to see. If this is true, what unique contribution can the nurse make to service delivery for a disadvantaged client who is pregnant? To examine this issue, it is important to look at the skills and knowledge attributed to community health nurses and influences on nursing practice. Additionally, it is important to consider what might be the unique needs and opportunities presented by the target group of women served by the Health for Two program.

1.2. Statement of the Problem

The Health for Two program is not designed according to any specific nursing or health promotion model. One section of the *Health for Two Program Manual* (Capital Health, 1999) mentions the transtheoretical model (Prochaska & DiClemente, 1992), but it is a brief reference and relates only to dealing with the issue of nutrition. Milk coupons and vitamins are provided to the clients, in addition to bus tickets to assist women to attend medical appointments. The program provides significant educational material for the client to take home. The information is prepared in the form of binders, which are given to clients. The content of the binders relates primarily to pregnancy and childcare with information about nutrition during the prenatal period. Although it mentions other issues such as violence and substance use, it does not address them in any detailed sense. Program material does not provide detailed strategies for assessing or working with

women in these areas. These are key issues for women, especially during pregnancy (Moore & Freda, 1998).

The main question for this research is, **In the absence of any stated model or theoretical framework, what is the practice of nurses delivering the Health for Two program in Capital Health public health centres?** Related sub-questions include: is there a clear and consistent nature to the practice or appropriate and responsive inconsistencies? Are similar strategies and values evident between nurses with similar clients? What issues are identified, and how do nurses assist women with working on the issues? What goals do nurses have when they work with women in a program such as Health for Two? Is there a difference between novice and expert practice? The purpose of these questions is to identify which elements are present when a community health nurse is involved in the delivery of a health promotion program such as Health for Two. Based on this, it may be possible to decide how to ensure that maximum value is being realized from the skills and education of the nurses. As a middle manager working in community health and responsible for two public health centres, I was able to gain access to the nursing staff across the region. It was proposed that the information collected in this study might be helpful in moving forward with program development, as additional funding for prenatal programs becomes available. A recent evaluation of the Health for Two program overall has described some tension between nurses and other professionals and agency workers who deliver the program and some disagreement about who delivers the program most effectively (Capital Health, 2000). The evaluation also suggested that there should be additional nursing resources to support the program but failed to identify exactly how the resources would be used. The qualitative information collected in this

study may provide additional insight into what added value nursing resources bring to non-health centre sites.

Nurses working in this program may have insights into what works and what might work better to reach and support women. Therefore, their input on these issues is a critical element. Combined with regularly collected input from clients who participate in the program, this research is likely to contribute to effective delivery of Health for Two.

As has been previously stated, pregnancy is an excellent time to connect with women who may be difficult to connect with at other times. It has also been demonstrated that pregnancy provides a window of opportunity in which women are interested in and capable of behaviour change. Based on this, is it possible that we are missing opportunities to work with women to make positive changes at this critical time?

Chapter 2

Literature Review

2.1 Introduction

This literature review will begin with a review of the context of social disadvantage, using a determinants of health framework. Specifically, issues such as poverty and women's health as they are relevant to practice in the area of prenatal care for disadvantaged women are explored. More specifically, the review will critique the extensive literature on disadvantaged women and pregnancy. This includes a significant range of issues that may affect a woman who is pregnant, such as substance use (which includes tobacco, alcohol, and other drugs), nutrition, violence and abuse, and access to medical care. In addition, the programs that have been developed to try to assist women to deal with these issues are varied and interesting, and deserve exploration.

The final focus of the literature review is the subject of community health nursing and the elements that are identified as a usual part of the practice. This portion of the review will look at the current environment in community nursing to see whether any changes have occurred that might influence practice.

2.2 Determinants of Health

The determinants of health can provide a framework for programs that seek to foster population health and reduce health-status disparities that exist for some groups, such as low-income women. The Lalonde (1974) report set the stage for looking at what makes people healthy instead of merely treating illness. That report established a framework for the key factors that seemed to determine health status: lifestyle, environment, human biology, and health services. Since the time that this report was

published, much has been learned that supports, refines, and expands this basic framework. In a document prepared by Health Canada Communications Directorate (1994) for a meeting of the provincial ministers of health, the following comments were made about determinants of health:

> The evidence indicates that the key factors which influence population health are income and social status, social support networks, education, employment and working conditions, safe and clean physical environments, biology and genetic make-up, personal health practices and coping skills, childhood development, and health services. Each of these factors is important in its own right. At the same time, the factors are interrelated. (p. 12)

Considering income as a determinant of health, women have on average lower incomes than men do and are concentrated in lower-status occupations. Therefore, a determinants of health perspective suggests that particular attention should be given to improving women's health through action targeted at the social and economic environment. Interventions focussed in these areas are one option for improving the health of these women. Changes that improve opportunities, for example, through the education and job training and the interventions that reduce stress to give people a greater sense of mastery and control over their lives, are also important considerations when planning and delivering programs for women.

Education and employment are health determinants closely tied to socioeconomic status. Effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals. Education is often related to the ability to secure employment and the type of employment that is available. The stress of unemployment is associated with more anxiety and depressive symptoms. Therefore, it is important for nurses to be aware of education and employment issues when they are working with women living in poverty. Connected to the issue of employment and

income is the availability of health and other benefits that may influence the women's ability to deal with health concerns for themselves and their new child.

Social support networks are a determinant of health that may help women solve problems and deal with adversity. "The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems" (Health Canada Communications Directorate, 1994, p. 16). In a program such as Health for Two, social support may mitigate the effects of poverty and isolation. "Social support is a significant concept for nurses because it influences health status, health behaviour, and health services use" (Stewart, 1995, p. 91). Operating within a framework that includes this concept, nurses connecting with pregnant women can provide support and referrals for women after the babies are born.

Healthy child development is identified as a separate determinant of health (Health Canada, 1994). For a program such as Health for Two, this is an important one. Low birth weight links to problems not just during childhood, but also in adulthood:

> Research shows a strong relationship between income level of the mother and the baby's birth weight. There is increasing evidence that intervening at critical stages in the development of children has the greatest potential to positively influence their later health and well being. (Health Canada, 1994, p. 25)

Hertzman (1998), in a pitch that supported child development as a determinant of health, pointed out that

> status differences at birth are associated with different levels of stability and security in early childhood which, in turn, affect the child's readiness for schooling. Lack of school readiness leads to an increased risk of behavioural problems in school and also, to school failure. (p. S17)

Focusing interventions before birth and early infancy period may improve child health. Health for Two is an intervention that is focused on these developmental stages,

and the program staff has the ability to refer women if they require additional support in dealing with other key developmental stages.

Personal practices such as smoking, use of alcohol and other drugs, healthy eating, physical activity, and other personal behaviours are considered health determinants as well. People's knowledge, intentions, and coping skills are important in adopting and sustaining healthy behaviours, but their social environments are even more important. In the 1990 Health Promotion Survey done by Health and Welfare, 48% of people said that support of friends and family was an important factor in making healthy decisions (Health Canada Communications Directorate, 1994). Teaching people about the components of a healthy diet is one thing. "Adequate incomes enable people to purchase the food they need for healthy diets for themselves and their children" (Health Canada Communications Directorate, 1994, p. 22). Viewed within a determinants of health framework, personal health practices are influenced by the social context. Health for Two is a program that is focussed primarily at the individual level. However,

> interventions with a behavioural focus stand more chance of success if information giving is supplemented with personal support or structural changes that help make behavioural change easier, and if the advice given is sensitive to the difficult circumstances in which many people live. (Whitehead, 1995, p. 33)

Within the context of Health for Two, some determinants of health, such as personal health practices, can be directly influenced through programs. Other determinants, however, will continue to affect the women in the program and deserve consideration in program planning and delivery.

The final determinant of health is health services.

> Health services, particularly those designed to maintain and promote health and prevent disease, contribute to population health. Preventive and primary health care services such as prenatal care, well-baby clinics, and immunization are very important for maternal and child health. Services that educate children and adults about health risks and healthy choices, and encourage and assist them to adopt healthy living practices, make a contribution. (Health Canada Communications Directorate, 1994, p. 25)

The determinants of health framework consists of six categories: income and social status, social support, education, personal health practices and coping, healthy child development, and health services. With an awareness of all of the determinants and the way they influence women, nurses working in Health for Two may be able to help women influence other determinants.

2.2.1 Poverty and Health

Poverty is one of the key determinants influencing the health of women targeted by Health for Two. The relationship between poverty and decreased levels of health has been documented and demonstrated consistently in the literature. One of the reasons identified for this link is that relative poverty reduces the ability of individuals and families to participate in a meaningful way in community activities (Williamson & Reutter, 1999). The National Forum on Health (1997) documented the correlation between social factors and health. They found that "people with high income and education levels tend to be healthier and live longer than people who fall lower on the socioeconomic scale" (p. 5). This report added that the connection between social status and health is even more evident when the gap between the rich and the poor is more pronounced and seems to be related to self-esteem, sense of control, and resiliency.

This concept has been supported in the Canadian literature and included in the landmark works of Lalonde (1974) and "Achieving Health for All" (Epp, 1986). *Report*

on the Health of Canadians (Health Canada Communication and Consultation Directorate, 1996) discusses the relationship between health and economic security. The report emphasizes the importance of undertaking policy initiatives in the area of economic security in order to move Canada toward improved health as a nation.

People living in disadvantaged circumstances face greater pressures when they work to change their behaviours. At a basic level, they have practical constraints of time, space, and money. The effort required to make positive behaviour change and to avoid health-damaging substances when living in poverty is daunting. In fact, use of substances such as tobacco is often a means of coping with environmental and social stress (Whitehead, 1995). Such information must be considered when designing programs. Consideration must be given to the individuals who will be participating, their circumstances, and their perception of what will and will not work for them.

2.3 Disadvantaged Women and Pregnancy

Pregnancy is a time of great physiological and psychological change for women. It is a time when women reevaluate their lifestyles and may modify health habits (Stotts et al., 1996). Women of low income are at risk for poor pregnancy outcomes (Gazmararian, Adams, & Pamuk, 1996; Sword, 1999). Their increased risk is embedded in a variety of determinants of health that interact with poverty, such as poor access to quality health services, lack of social support, and risky health behaviours. Lack of social support may be associated with behaviours such as smoking and using drugs or alcohol (Maloni, Cheng, Liebl, & Maier, 1996).

Numerous studies of low birth weight have linked maternal risk factors and behaviours during pregnancy to adverse birth outcomes. These risk factors include

maternal health conditions, smoking, alcohol use, drug use, previous low birth weight, short interpregnancy intervals, and prenatal care (Johnson, Drisko, Gallagher, & Barela, 1999). Low birth weight can be a predictor of poor early childhood development. Health Canada Communications and Consultation Directorate (1996) said that babies with low birth weight are at increased risk of illness and death. The issue of low birth weight as a poor pregnancy outcome continues to be evident in the Capital Health region (Capital Health, Regional Public Health, 1997; Marshall, 2000). The following sections highlight a range of issues that may affect a disadvantaged woman who is pregnant.

2.3.1 Health Services

Childbearing women who seek prenatal care are a diverse population with diverse needs. Their age range spans several decades, and physical, psychosocial, learning and social-support needs vary with age and with marital status (Merkatz & Thompson, 1990). Mikhail (1999) reported that the women who most need to access service during pregnancy may not do so because of perceived barriers to service. Sword (1999) found that "fragmentation of care and inconvenient clinic hours were barriers" (p. 1171). She also found that "lack of knowledge about available prenatal services, lack of perceived importance of or need for care and negative attitudes towards health professionals and health services are additional barriers" (p. 1172). Sword also suggested that "prenatal care, in the broadest sense, encompasses community based programs which provide support for a healthy lifestyle, foster linkages with health and social services, and add to existing social networks" (p. 1170).

2.3.2 Abuse

Abuse is a significant risk factor during pregnancy. Public health officials have recommended that standard protocols be implemented to screen for abuse during pregnancy. It is believed that early identification, supportive education, effective referral, and ongoing support for women at primary care sites could eventually reduce the incidence of abusive injury (Shepard, Elliott, Falk, & Regal, 1999; Wiist & McFarlane, 1999). In spite of these recommendations, assessment and documentation occur at a very low rate in prenatal settings. "Prenatal care provides a window of opportunity to implement abuse protocols in public health clinics" (Wiist & McFarlane, 1999, p. 1220). Inadequate assessment of abuse and lack of appropriate intervention by nurses and other health care providers present major barriers to the care of abused women (Moore, Zaccaro, & Parsons, 1998). Implementing programs to identify this issue in pregnancy results in improved safety behaviours of women and adolescents (McFarlane, Parker, Soeken, Silva, & Reel, 1998; Parker, McFarlane, Soeken, Silva, & Reel, 1999; Renker, 1999).

2.3.3 Substance Use

Use of substances of all types as an issue takes on increased focus for women of all ages who are pregnant. Studies have suggested that pregnancy outcomes of substance-abusing women improve with comprehensive care, treatment services, and other social services (Lieberman, 1998). Teenagers use drugs at an alarming rate in our society for a variety of reasons, including peer pressure, social acceptance, psychological problems, and family history. The effect of drugs causes teenagers to be less inhibited and may lead to unsafe sexual practices. This places substance-using teenagers at increased risk for

becoming pregnant (Richardson, 1999). Teenagers who are pregnant and abuse drugs are at high risk for pregnancy complications and place their developing fetus at increased risk. Nurses who care for pregnant adolescents are in an ideal position to assess for signs and symptoms of substance use, provide education, initiate intervention and referrals, and ensure follow-up. The developmental level of the adolescent is an important consideration when planning interventions.

2.3.4 Smoking

Maternal smoking during pregnancy is recognized as an important and modifiable risk factor for low birth weight (Ershoff, Mullen, & Quinn, 1989; Groff, Mullen, Mongoven, & Burau, 1997; Windsor et al., 1993). High rates of smoking are found among women who are considered to be disadvantaged in one or more of the following ways: poverty, unemployment, low occupational status, geographic isolation, and lack of social support (McCormick et al., 1990; Stewart et al., 1996). In the study done by Stewart et al., most women were aware of the harmful effects of smoking on the fetus, and many reported attempts, both successful and unsuccessful, to stop or reduce their smoking during pregnancy. Another study concurred that women were aware of reports that cigarette smoking may be harmful to a developing fetus, and the majority believed the reports to be true but identified barriers to quitting (Dunn, Pirie, & Lando, 1998). The majority of women reported taking active steps to minimize risks, including cutting back, changing brands, and quitting. The recommendations from this study that have implications for health promotion include the need for clear and consistent messages about the importance of quitting smoking during pregnancy, more information about passive smoke and how to limit its effects on pregnant women and infants, and programs

developed for groups of women to assist them in smoking cessation. Pregnancy would seem like an ideal time to help women quit smoking because motivation for behaviour change already exists, and prenatal care provides an opportunity for multiple contacts with the health system and other supports (O'Connor et al., 1992). Women who have immediate intervention have higher rates of smoking cessation. This supports the need for individuals who see pregnant women to be able to deal with the issue of smoking on the spot.

In 1996 Capital Health and Health for Two commissioned a background paper *Tobacco, Alcohol and Drug Use During Pregnancy* (Horne, 1996). In this report the focus was on the Health for Two clients and issues specific to addictions.

> Women who live in high-risk environments (e.g., substandard housing, exposure to violence) and who do not have access to resources, support and information may use substances to cope with their negative environments. Many of the Health for Two participants live in such environments. (p. 1)

This paper provided an extensive summary on the issues surrounding addictions and acknowledged that information alone does not promote behaviour change. In order to change behaviour, women need supportive environments, opportunities to develop and enhance skills, adequate resources, and supportive policies.

In summary, disadvantaged women may be faced with a variety of interrelated risk factors embedded within determinants of health, such as personal health practices, lack of social support, inappropriate health services, and, ultimately, poverty. The next section addresses the role of nursing in addressing the individual and social context of disadvantaged pregnant women's health.

2.4 Role of Nursing

The nurses who work in public health centres delivering Health for Two in Edmonton are community health nurses who are educated at the baccalaureate level. The terms *public health nurse* and *community health nurse* are used interchangeably in some literature and distinctly in others (King, Harrison, & Reutter, 1995). For the purposes of this review, references to the work and skill sets of both will be considered.

2.4.1 Competencies and Expert Practice

Zerwekh (1991a) wrote about the expert competencies of public health nurses in visiting high-risk maternal-child clients at home. The group of nurses who were interviewed for her study worked primarily with families who were impoverished and in which drugs, alcohol, disorganization, and violence dominated the households. The nurses struggled with doubt about whether they were making any difference. "Traditionally, they have learned that they made a difference through small tenuous changes with outcomes that may take years to be manifested" (p. 59).

Zerwekh (1991b) stated that the issue of expert practice has not been well described in the area of public health nursing. She described a model that illustrates the nonlinear relationship between competencies required to work with vulnerable families "to develop their personal capability to take charge of their lives and make change" (p. 214). A variety of competencies were identified as being part of this model. The competencies include locating (actually finding the families), building trust (discovering and affirming strengths and not judging), and building strength (especially with women as persons and as mothers). Additional "encompassing competencies" (p. 215) were also identified. These include timing (detecting the right time) and persisting. Detecting is

described as an ongoing competency and relates to the nurse's ability to identify a variety of factors, such as environmental issues, family dynamics, mother's needs, and physiological alterations. Other elements of the practice include being available, mobilizing resources, collaborating with professionals, resolving problems, resolving crises, working through emotions and fostering family understanding, parent education, and persuading.

Zerwekh (1992b) wrote about the role of nurses working in community and the concept of *empowerment* as it related to their practice. She defined empowerment as "enabling a parent to develop personal capacity and authority to take charge of everyday family life" (p. 102). Wallerstein (1992) also described the concept of empowerment as "a multi-level construct that involves people assuming control and mastery over their lives in the context of their social and political environment" (p. 198). This is an idea that supports the variable of control as a health enhancer.

Public health nurses can use strategies to encourage family self-care, an important practice concept (Morgan, 1994). Strategies for working in this way include believing that families have choices and helping them to believe that they do, listening to family concerns and starting where they want to start, expanding the family idea of realistic possibilities, and feeding back reality in a straightforward way.

Zerwekh (1992b) also discussed the issue of coercion as it relates to child protection. Public health nurses are strong advocates for the families with whom they work, but when reasoning is not successful, there is a legal and moral obligation to invoke authority. This is a difficult and not infrequent role for the nurse working with extremely at-risk families. It involves balancing "respect for parent with concern for the

child" (p. 104). This is an extreme but not rare situation. It tests the nurse's relationship with the family, but the emphasis is on empowering the family in even this most challenging circumstance.

Although domestic violence is a serious problem that affects women's health and pregnancy outcomes, nurses are hesitant to address this issue with women if they do not have the training to do so. More training related to abuse and more time to spend with women are suggested as necessary for nurses to be able to respond to women for whom abuse is an issue. Education and comprehensive protocols would strengthen nursing interventions for abused women (Moore, Zaccaro, & Parsons, 1998; Selleck & Redding, 1998).

2.4.2 Effectiveness of Nursing Interventions

Deal (1994) found that models of effective community nursing intervention occur at two levels: home-based interventions and community-level interventions. Interventions with pregnant women fall into both categories. Home visiting with at-risk women has proven to be effective if it starts in the prenatal period and has resulted in behaviour change in the women (Olds, 1992; Olds & Kitzman, 1990). Some of the strategies in the home visiting programs involved life skills training to assist women in decision making. Community interventions that work with disadvantaged pregnant women include those that use community health nurses to break down barriers that prevent women from accessing prenatal care.

One home-visiting program that started in Elmira, New York, and was replicated in Memphis, Tennessee (Kitzman et al., 1997), involved nurses visiting women during pregnancy and for two years after the birth of the baby. After the program was finished,

the evaluation demonstrated that women showed an increase in their sense of mastery. "Mastery is a general psychological attribute that affects parents' ability to cope effectively with a wide range of challenges" (p. 652). Mastery is consistent with individuals having a greater sense of control over their environment, which is one factor that contributes to health and is consistent with the concept of empowerment.

Peer-mentoring programs are an example of community interventions that have been shown to be very effective when working with groups of marginalized women. In many of these programs community health nurses perform in a training and resource role for the peer mentors. There are many examples of such programs in the literature. A program called *De Madres a Madres* (McFarlane & Fehir, 1994) is an inner city program in a Hispanic community in Houston, Texas. Another peer-mentoring program is a prenatal peer-counselling program in Quebec (Lapierre, Perreault, & Goulet, 1995). A third program in which women become mentors to other women is a program designed to influence breastfeeding practices among low-income women in Chicago (Kistin, Abramson, & Dublin, 1994). In each of these cases, collaboration occurred between community workers and community health nurses and resulted in positive outcomes for disadvantaged women served by the program, as well as the mentors themselves. Because Health for Two is delivered to help women learn to make better decisions for themselves and their families, women may emerge from the program with an interest and ability to support other women. This could be an opportunity for nurses to serve as a resource to develop skills in peer workers.

Working in the area of health promotion, nurses can operate within an idea of what O'Keefe (1995) called *personhood.* This concept relates to the theory that correct

information has limited effectiveness on its own to bring about change in behaviour. This perspective advocates that programs be centered on the individuals who participate in them. This would include a focus on each individual's concerns and priorities, views about what she needs, and a sense of whether interventions will be acceptable to her. This approach treats people as having rights and emphasizes the nurse's ability to respect the user of the service and to adopt a role of facilitation. The idea is to act in a partnership with the client. In this type of relationship, every contact is an opportunity for health promotion.

The idea of "salvaging self" (Kearney, Murphy, Irwin, & Rosenbaum, 1995) is identified in relation to the use of crack cocaine during pregnancy. This concept is the basis for a program in which nurses work to assist women who are using drugs during pregnancy to redirect their lives and make the best of an already damaged pregnancy. The focus of that program is harm reduction and includes developing interventions that enhance self-care and reduce drug-related harm for pregnant women who are unable to stop using drugs. The discussion of this program affirmed that nurses must have special skills and attitudes to work with pregnant women who are using crack cocaine, but community strategies are necessary as well.

Reutter and Ford (1998) discussed the issue of perceptions of changes in public health nursing practice from a Canadian perspective. In their research, nurses described becoming more involved in collaborative efforts with other community partners and a fear that with decreasing resources only the most at-risk clients will be served. They also expressed concern that with regionalization, the competition for dollars with acute care services may threaten health promotion and illness prevention programs. Health for Two

is a program that is a result of collaboration, and if resources are to be focused on only the most at-risk, then this program should continue. In that case it would be even more important for nurses to be able to demonstrate that they are doing the "right" things in the delivery of Health for Two and that the program is making a difference.

2.5 Summary of the Literature

There is a clearly identified connection between poverty and poor health. Women with low incomes are at risk for poor pregnancy outcomes. Pregnancy provides a window of opportunity in which women may work to decrease modifiable risk factors such as smoking, substance use, and domestic violence. Community health nurses typically work with at-risk individuals and families to empower them to make slow, incremental changes in health-damaging behaviour. They do this within a health promotion framework that includes consideration of the many factors which influence health and within which behaviour change occurs. If community health nurses have the education, training, and support to do this work comfortably, they are ideally situated to do so.

Chapter 3

Methodology

The purpose of this research is to explore and describe the essence of community health nursing practice in the delivery of Health for Two, a prenatal health promotion program. The research will be guided by the following research question:

> **In the absence of any stated model or theoretical framework, what is the practice of nurses delivering the Health for Two program in Capital Health public health centres?**

The purpose of the study is consistent with an exploratory and descriptive research design with qualitative methods (Marshall & Rossman, 1995). These researchers suggested that "the strengths of qualitative studies should be demonstrated for research that is exploratory or descriptive and that stresses the importance of context, setting, and the participants' frames of reference" (p. 44). This is important for research on Health for Two because it is a program that is targeted at a specific group of women whose pregnancies may be influenced by their own "frames of reference." It is important to know whether nurses delivering the program function within that paradigm. Because the program is delivered in a variety of ways in a variety of settings, it is important to capture those variations in order to identify whether they influence program delivery. This piece of information can be partially obtained by observing the program at the sites. The additional information captured in the questionnaire will add to learning about the "frames of reference" of the nurses.

Patton (1990) suggested that qualitative research approaches emphasize the importance of getting close to people and situations being studied. He believed that this

must be done to "personally understand the realities and minutiae of daily life, for example, life in a program" (p. 46). He proposed that "the advantages of qualitative portrayals of holistic settings and impacts is that greater attention can be given to nuance, setting, interdependencies, complexities, idiosyncrasies, and context" (p. 51). This idea was supported by Miles and Huberman (1994) who stated that: "The researcher's role is to gain a 'holistic' (systemic, encompassing, integrated) overview of the context under study: its logic, its arrangements, its explicit and implicit rules" (p. 6).

Nurses are always involved in the delivery of Health for Two at the public health centres. Nurses working in any program have a variety of employment and life experiences. Some have been working in community health nursing for many years, and this experience has provided them with background as generalists. Other, more recent graduates have entered a working environment in which there is a more focussed practice in specific areas. Nurses may not have had the experience of working with individuals who are living in poverty. This study is intended to identify whether these variations in work experience create inconsistencies in delivering a program that varies considerably in size from community to community. The method is intended to document what is actually happening, including the significant themes, behaviours, attitudes, structures, and processes that are occurring.

The information collected by observing the program is supplemented by other data collected through a questionnaire. The questionnaire is intended to explore the practice of nurses further as they describe that practice in response to open-ended questions. "Designing a study in which multiple cases, multiple informants, or more than one data gathering method are used can greatly strengthen the study's usefulness for

other settings" (Marshall & Rossman, 1995, p. 144). This is referred to as *triangulation of data*.

3.1 Phase One: Observation

3.1.1 The Participants

The first phase of the research study consisted of observing the Health for Two program at each of the public health centres. The principal investigator observed all of the sessions. To arrange this, the researcher contacted the managers at all of the sites to ensure that they were aware that data collection was occurring and to have each one identify the key staff members involved in the delivery of the Health for Two program at their sites. The key staff members were then contacted. Contacts from every site responded promptly to the request to observe the delivery of the program.

The participants in the observational phase of the study were a sample of 13 nurses who were involved in the sessions that were observed. These nurses are the ones who deliver the program regularly, but not the only nurses who may see clients accessing the Health for Two program at public health centres. Because of this, additional nursing staff members participated in the completion of the questionnaire, which is part two of the data-collection process.

3.1.2 The Sessions

The Health for Two program in Capital Health is delivered in a number of different ways by a different number and variety of staff. Eleven sessions were observed, and each session was associated with a different public health centre. In the course of these observations, the researcher had an opportunity to observe a total of 13 community health nurses delivering the program, 68 clients, and 7 of the clients' partners. The clients

ranged in age from 17 to 38 years of age. Most of the sessions included at least one older child belonging to one of the pregnant women. The sessions occurred between October 26, 2000, and January 26, 2001. The total number of clients enrolled in the program at any given site ranged from 4 to more than 100. Based on the program mandate, this caseload reflects the demographics of the communities in which the public health centres are located and in part determines the way in which the program is delivered. For example, in a community in which there are only four women enrolled, it would be unlikely that a group could be offered exclusively for Health for Two clients. On the other hand, in an area where there are 100 or more clients, it would be difficult to have the human resources to see them regularly on a one-on-one basis.

Patton (1990) commented that "the evaluator sets out to understand and document the day-to-day reality of the setting or settings under study" (p. 420). There are a number of different types of sites, and this creates a variety of contextual environments for program delivery. When observing the programs, it was important to consider the elements of the site. Patton stated that

> the physical environment of a program can be important to what happens in that environment. The way the walls look in rooms, the amount of space available, how the space is used, the nature of the lighting, how people are organized in the space, and the interpretive reactions of program participants to the physical setting can be important information about both program implementation and the effects of the program on participants. (p. 220)

It is important to capture what is happening in the environment because the environment has an effect on the way the program evolves. The environment may relax and invite people, or it may make them feel uncomfortable. Either way, it can contribute significantly to the success or failure of the interactions that occur there.

> The nature of the program emerges from the interaction of the physical setting, the social environment of the people in the program, the nature of staff leadership and administration and the activities provided for in the program. The "personality" of the human, social environment will affect how program activities are perceived and experienced by participants. (Patton, 1990, p. 223)

Although the researcher has some prior experience in observing the program at three health centres, it is important when seeking to situate information collected within a context that all environments within which the data are collected be observed.

In order to document the elements of the environment, an observation guide was used (Appendix A). The following categories were part of the guide: setting, human or social environment, planned program, informal interactions, and language of the program. These categories influenced the way the observation sessions are captured. Each session was documented under these headings, but as the researcher progressed from session to session, the increased experience gained with program observation created the need to ask certain questions in later sessions. These questions included "How many clients in total are on the program at your health centre?" and "Do you ever make home visits to the clients on the program in the prenatal period?" This additional information was gathered from the nursing staff who had been observed in the earlier sessions at the time the written observation notes were sent back to them for verification. The answers to these questions added to the knowledge about the complete context in which the program is delivered. This information could not have been gained through observation alone.

One of the limitations of this study, however, was the fact that since it was important to ensure that all replies to the questionnaire were anonymous, it was impossible to tie the responses to the specific site observation. Being able to link these

two together would have enhanced the interpretation of the data collected in the questionnaire.

3.1.3 Client Consent

Although the focus of the observations was the nurses, it was important to explain to the women in the program why the researcher was present and to gain their permission before proceeding to observe the group. The nurse delivering the program explained the study and obtained permission from women participating in the program prior to the researcher's observing the sessions. The fact that permission was asked for and received was noted in the field notes on the observation guide. Women asked some questions of the researcher, but in each case they were supportive of the process and indicated support of the program and program staff as well. The majority of women did not appear to be inhibited by having an observer in the group. Often, as the group or session progressed, the women focussed on the discussion and the other group members and appeared to forget that the researcher was present.

3.2 Part Two: Questionnaire

Phase two involved the administration of a questionnaire (Appendix B) to nurses who deliver this program. There is always a trade-off between breadth and depth in a study like this (Rossman & Rallis, 1998). In-depth interviews of a smaller number of nurses would not have allowed for collection of sufficient data to identify consistent practice across the program. Marshall and Rossman (1995) noted that survey questionnaires are conducted to learn about the distribution of characteristics, attitudes, and beliefs in a specific population.

3.2.1 Questionnaire Development and Validation

The questionnaire that was used employed entirely open-ended questions. Using a questionnaire with rating scales would not have allowed for spontaneous and creative answers. Patton (1990) said that open-ended questions permit "the respondent to describe what is meaningful and salient without being pigeonholed into standardized categories" (p. 46). The questions (Appendix B) were designed to identify the issues with which nurses are dealing in the program.

Demographic data collected through the questionnaire asked nurses to identify how long they had been involved in community health nursing, how long they had been delivering the Health for Two program, and how often they participated in program delivery. These elements were collected to aid with data analysis in establishing whether there was any correlation between practice patterns and years of experience.

The first substantive question related to the issues that nurses address with women in the program. The second question examined what nurses are trying to achieve. It was intended to identify whether the nurses' goals are the same as the goals identified by the program material. The third question related to strategies used to achieve program goals. It asked nurses to describe how they do what they do. This question was designed to identify the range of approaches that nurses use when they work with clients and whether there is some consistency in these approaches. The fourth question asked how nurses know they have been successful. This question is designed to establish how nursing staff members who work in Health for Two know what difference they have made; how do they measure outcomes? The final question asked what would make the program more comprehensive and better for women. This may establish how nurses feel about the

program and whether they have thought about how it could be better. It is my belief that people who deliver the program have the best knowledge of its strengths, weaknesses, and what they envision.

Providing a questionnaire that is short, focused, and clear is likely to increase the response rate. Therefore, the questionnaire was formatted with large blank areas for responses to make the response task appear easier and simpler. The questions were pilot-tested with a group of five nursing staff from three different public health centres. Nurses were asked whether the questions were clear and whether they had suggestions on how to clarify them. After discussions with the nurses, minor adjustments were made to two of the questions for clarity.

3.2.2 Questionnaire Administration

Personal contact by the researcher with the nurses through observation of program activities seemed to encourage them to participate in this second part of the data collection process. The method of informed consent and the format of the questionnaire were explained to a key contact person at each site to assist with distribution of questionnaires to other Health for Two nurses who may not have been involved with the session on the day of observation. At sites where more than one nurse was involved in the program, at least one other nurse was asked to complete the questionnaire. It was the researcher's opinion that this would provide input from nursing staff who delivered the program in a variety of circumstances. This resulted in a total of 21 questionnaires being distributed. A record was kept of the number of questionnaires distributed to each health centre so that follow-up could occur if necessary. It was not necessary to do any follow-

up because all questionnaires were returned within two or three weeks after they were distributed.

When the questionnaires were distributed, a covering letter explaining the purpose of the study was attached. It was stressed that the research was concerned with program evaluation and not individual evaluation. It was requested that the questionnaire be returned in a preaddressed envelope through interoffice mail. Envelopes were indistinguishable from one another.

All of the questionnaires were returned (100% response rate). This included 21 nurses working in 11 public health centres. This study was supported within the agency where it was being done, and it was expected that the return rate would be high. Because mail surveys with response rates over 30% are rare (Alreck & Settle, 1995), the personalized administration procedures were apparently effective.

The detailed responses and demographic information gathered through the questionnaire added to the information gained through the observation of the program at each site. The observation data provided the context for information that was identified by nursing staff who responded to the questionnaire. This sample provided a representation of the variety of ways in which nurses describe their practice, and thus should be helpful in trying to document diversity or understand variation in this practice (Patton, 1990).

3.2.3 Ethical Considerations

Because this study involved human subjects, procedures were followed to ensure a high ethical standard. First, permission to conduct this study with nurses in the public health centres was obtained from the Director of Community Health Services in Capital

Health, the division in which this program is delivered. Second, the research proposal was reviewed and approved by Panel B of the Health Research Ethics Board, University of Alberta. As a result of this review, the cover letter and the consent form provided enough information to participants to be sure they could give informed consent for the observation portion of the study (Appendix C). Returning the questionnaire implied consent for the second part of the study. Participants were told they had the right to inquire about the research and were given the names and phone numbers of independent individuals who could answer their questions. Participants were assured that all results would be treated confidentially. They were assured both verbally and in writing that descriptions and quotations would not identify individual respondents in any way. Presentation of information gained would be done only with aggregate data to ensure that no individual responses could be identified.

Because the researcher is a middle manager in the agency in which the data were collected, it might have been a consideration that some individuals could have concerns about confidentiality or that they could feel coerced to participate. Reassurance about these concerns was offered. Consent forms assisted with this, but staff members were assured that participation was purely voluntary. Sufficient trust was necessary to achieve an acceptable return rate from the questionnaire.

3.3 Data Analysis

In qualitative research, data analysis occurs not only at the end of data collection, but also throughout the process. "In the course of collecting data, ideas about possible analysis will occur" (Patton, 1990, p. 377). Field notes were made at every step to reflect what was observed as well as how the researcher felt about what is happening. Rossman

and Rallis (1998) described the stages of data analysis as organizing; familiarizing yourself with the data; generating categories, themes, and patterns; coding the data; searching for alternative explanations of the data; and writing the report.

During the first phase of the study, data analysis included reviewing and writing the field notes from each observation session as soon as the session was over, and asking the staff member who delivered the program to review it to establish whether it accurately reflected what happened. Once the content was verified, it became part of the data set for analysis.

During the second phase of data collection, when the questionnaires were returned, it was important to read each response to develop an understanding of the data. Data collected from the survey were collated by question in a cumulative fashion under headings for each question. The responses were analyzed for common themes and coded for these themes. In qualitative research, most analysis is done with words (Miles & Huberman, 1994). This was what Patton (1990) described as inductive analysis because the patterns, themes, and categories of analysis were identified from the data.

For this study it was important not only to identify themes, but also to quantify the responses, which meant looking at frequency and rate of specific responses to provide information regarding the strength of some themes. With a larger sample size it is important to document how often similar responses are identified. This speaks to the concept of consistency or inconsistency in practice and philosophy. The relationship between responses to different questions may provide insights into the connection between goals, identified issues, and strategies. To explore the idea of novice and expert

practice, the relationship between practice style and years of experience was examined for trends.

Chapter 4

Phase 1: Observation Results

Health for Two is delivered in all public health centres, and, as has been previously stated, it is delivered in a number of different ways. The Health for Two program includes a variety of components. Milk coupons are distributed for improved nutrition, free prenatal vitamins are distributed if women do not have other access to them, and bus tickets are available to assist with transportation to appointments. Each woman receives a program binder and additional nutritional information. In addition to these core program elements, women have access to other resources, the nature of which is dependent on the site at which the program occurs.

At each of the sites, community health nurses deliver the program. Of note, all of the nurses involved in the program expressed their enjoyment in delivering the program and were committed to the client group the program serves. They put considerable effort into planning and implementing the program and into the relationships that they develop with program participants. They expressed an interest in participating in the research in the hope that the findings would assist them to provide the best program possible.

4.1 Setting

4.1.1 Public Health Centre Meeting Rooms

Of the 11 observation sessions, five occurred in the large meeting room of a public health centre. Typically, these rooms are used for a variety of functions. They have tables and chairs suitable for meetings but are frequently decorated with posters about breastfeeding, family violence, nutrition, community events, and support services. For the

Health for Two program sessions, additional resources are brought into the meeting room. These additional resources include the following.

Birth atlases. These are books that are called *With Child* (Childbirth Graphics, 1995). They provide a graphic account of a variety of subjects related to pregnancy and childbirth, including preconception, infertility, genetics, growth of the babe, labour and giving birth, postpartum, the newborn and breastfeeding, and parenting. The books include a description of each picture, but it is the pictures that appear to be of considerable interest to women. The women look at the atlas and find the picture that is closest to their own gestational stage. This prompts them to ask questions of the nurse, which provides an opportunity to deliver information in a targeted and responsive way. This can often include another client who may be further along in her pregnancy or who may have already delivered. The interaction in these events is significant and was observed on a regular basis.

Videos and books. Educational videos on subjects related to pregnancy, childbirth, and childcare are present in a number of the sites. In two sites video machines were available for individuals to use. In one of those sessions, the video was running throughout the group session. Surprisingly, this was not distracting, and although women did not watch it in its entirety, several noticed it and asked to borrow it to watch at home. In spite of the fact that this program is provided for disadvantaged women, many have video machines at home. If they do not, they can watch videos at the health centres.

Books are available at many sites. Some of the clients of this program did not attend prenatal classes and so were not provided with the books that are a usual part of these classes. These books are made available at many health centre sites. Nurses said

that they are always on the lookout for other appropriate material to use with this client group. "Appropriate" would mean that the material is suitable for individuals with lower literacy skills and others for whom English is a second language. In one Health for Two session, a client brought a book on labour and delivery that she found to be written in a clear and simple manner. She had found it helpful and brought it to share with other group members.

Health for Two binders. The Health for Two binder called *Your Pregnancy* (Capital Health, 2000) is part of the program and is provided to each woman to take home and keep. The binder is written at a Grade 6 level and is designed to be easily understood by women who attend the program. The binder was revised in 2000 and contains information on many issues that may be helpful to a woman as she moves through the stages of pregnancy and childbirth.

The manual deals with a variety of topics. These topics include healthy eating, safety (including violence, alcohol, smoking, and drugs), development of the fetus trimester by trimester, warning signs, labour, and birth. There is also a section for dads. The binder contains sections in which women are encouraged to make notes and personalize. Typically, once they have taken the binder home, women do not bring it to the sessions with them. Therefore, the nurses have at least one copy of the binder at the sessions available for reference.

Other resources. In public health centres, nursing staff also have access to the normal resources of the centre. These include birth control information kits, breastfeeding information and supplies, child passenger restraint demonstration material, and all of the educational pamphlets on child safety, child and adult nutrition, and community

resources. In two sites staff identified and clients discussed presentations that had been provided by community police and firefighters in the area of personal safety and fire prevention.

4.1.2 Public Health Centre: Smaller Counselling Room

At two sites the program was delivered in individual counselling rooms. In one location, the program is delivered in an ordinary clinic room. At this site, there are only four women in the program and no need to run a group specifically for the program at this site. The second location where the program is delivered in an individual room has a specific room that is decorated and furnished primarily for the Health for Two program. In this room there are a couch and rocking chair and a large number of resources immediately noticeable. There are books, posters, videos, and a video player. The room has pleasant children's pictures and educational posters related to prenatal care and childbirth.

4.1.3 Community Health Centre: Women's Health Clinic

One site where the program was observed is a community health centre in the Women's Health Clinic. The program was delivered either in an examination room or in a small room adjacent to the clinic area. The adjacent room has been made less clinical and more comfortable by the addition of a rocking chair, and there are plans to add some other more comfortable pieces. Nursing staff who work in the clinic deliver the program during clinic time and at other times of the week. Some clients of the program see physicians in the women's health clinic, and others attend only for the Health for Two program. Clients are seen one-on-one, although occasional group functions are planned with the assistance of the Health for Two network and the network coordinator, who

supports all of the community agency sites and the health centre sites in a specific area of the city. The group events are primarily of a social nature at the present time. The idea of holding a drop-in group at this site is being considered. At present there are 54 clients on the program at this site.

4.1.4 Home Visit

As part of the observation of the program at one site, the researcher observed a home visit. At the site where the home visit was observed, there are six to eight clients on the Health for Two program at one time. A previously scheduled observation session had been cancelled because of the birth of the woman's baby. Instead, the observation was done at the home of a different client. Home visits are done occasionally, although not regularly as part of the Health for Two program. In this particular situation, clients are usually seen one-on-one at the clinic or in their homes when finding transportation is a challenge. Clients at this site also have access to a group run by a community agency to augment nursing service with social support. Referrals to the group and to the Health for Two program are made by a variety of community services, including an alternative school, physician's offices, and other agencies.

In the home visit that was observed, it was possible to get a picture of the challenging circumstances in which the young woman was living. A sense of the issues with which she was coping because of her youth, social history, and low income was gained while sitting with her in the basement room she was renting. She described her isolation and how difficult it was to get out and see other people. There was no bathroom in the basement, and she needed to go upstairs and was afraid of disturbing the people who lived there. As her pregnancy progressed, the number of times she needed to get up

in the night increased. There were toys and childlike things that belonged to her that reflected her youth. This was information that could not have been obtained in the same way if the client had tried to describe it. In fact, there were nuances in the environment that she may not have even thought about.

A nurse at each of the observation sites was asked whether she made home visits as part of the program. Nurses at half of the program sites did make home visits occasionally. More stated that they would appreciate being able to have the time to do home visits when women were unable to attend the program. This was also identified as a strategy that some nurses would like to use when they are trying to follow up on women who have dropped out of the program. The use of home visits in community health nursing practice is supported strongly in the literature:

> The advantages to making home visits are many. Home visits permit health care services to be integrated into the client's usual routine. For clients who are immobile or lack transportation, the home visit affords access to healthcare that might otherwise be unavailable. The nurse making the home visit may gather information about the client and the client's environment less easily obtained in other settings, including information about resources and hazards, and the extent of the client's social network. (Clark, 1999, p. 18)

Other programs have been successful in using home visiting as a strategy. Two of these were described in the literature by Deal (1994) and Olds and Kitzman (1990). The programs that they described were targeted at disadvantaged women. In fact, intensive home visiting programs that are delivered to women in the prenatal and postnatal period have been very successful in supporting positive parenting and in preventing child abuse. Olds (1992) commented that home visiting programs have been helpful in linking women to prenatal health services.

4.1.5 Community Agency Sites

Two of the program sessions delivered by nurses from the public health centres are delivered at outreach sites in community agencies. The community agencies in question offer complementary programs and resources for the clients. At these sites, there is an additional aspect of relationship building as program staff have access to programs and relationships with other service providers. These relationships enhance services to women in Health for Two. In both locations there is a play area for older children who accompany their mothers to the program. There is a kitchen area in both sites as well. This facilitated the preparation of food, and at each site lunch was served prior to or as part of the program. In both cases, the program supplies, including milk coupons, program binders, charts, and other support material such as bus tickets and pamphlets, are carried to the site by the nursing staff. At one location the baby scales were brought as well so that mothers would be able to weigh their babies when they had them with them. One of the sites had a clothing exchange, and both sites had access to multiple rooms so that women could be seen one-on-one in a separate room if they desired privacy to talk. Both of these locations provide on-site access to Rhymes That Bind, a children's literacy program that encourages mothers to read to their babies. At one agency site, the agency provides parenting and parent support programs. These programs are more easily available to the women who attend. This easy access makes it easier for individuals to attend.

4.2 Human or Social Environment

Health for Two is delivered in program groupings that range in number from 1 to 15 women. In five of the groups there are more than eight women. In most of the group

program settings where there are large groups, the participants appeared to be very familiar with the other group members and with the staff members as well. The atmosphere in each of the sites was relaxed and very welcoming. It was noted that the nursing staff and other staff members appeared to have developed relationships with the women who were program participants. They displayed a caring attitude toward the women and their babies, and the warmth of these interactions was tangible and very positive to watch. This observation fits with the idea that community health nurses have a relationship-based practice as identified by Anderson and McFarlane (2000): "Nurses are fundamentally responsible for facilitating relationships that promote a sense of connectedness" (p. 99). This can also be referred to as social support, one of the key determinants of health. It is a significant concept for nurses because it influences health status, health behaviour, and health-services use. "Social support is defined here as interactions with family members, friends, peers, and health care providers that communicate information, esteem, aid and emotional help. These communications may improve coping, moderate the impact of stressors, and promote health and self-care" (Stewart, 1995, p. 93). Social support can also be defined as "resources provided by others. These resources can be in the form of emotional support, instrumental aid (e.g., money and housing), information (advice, directions, and suggestions), and positive feedback to one's importance or self worth" (Oermann, 1991, p. 71). These quotations imply that the community health nurses can develop relationships with clients to help them feel connected and supported. Through these connections and supports, it is believed that women may be able to engage more easily in health-promoting behaviours.

The camaraderie among the clients was clearly observable at each of these locations where group activities occurred. Women at various stages of pregnancy, as well as those with babes of various ages ranging from two days to almost one year were present at several sites. At some sites the cutoff age of two months postpartum was adhered to, and at other locations milk coupons are stopped at two months of age, but group members participate until the child is one year of age. In some groups, by this time, some of the women are pregnant with another child and continue to attend the group. It appears that many participants see the group sessions as a social opportunity and gain social support as well as practical support from other group members. As mentioned before, social support is identified as a key determinant of health.

On two occasions it was also observed that a new participant in the group appeared to have difficulty breaking into the group because of the strong relationships that were evident among the other members. This may present barriers to new members. Because of the sustained and strong relationships of the other group members, new members, especially those who are shy, may not feel comfortable attending. This is an issue that group facilitators should watch for so that they can follow up with those new members to ensure that they feel welcomed and will return.

Whatever the setting, the Health for Two program in Capital Health public health centres is delivered by nurses. Each public health centre has a nurse on call at the site every day. This nurse sees clients who drop in to the health centre. One nurse who sees women on the Health for Two program primarily when doing nurse call said she would like "more consistency with the same mothers so they got to know us and felt more

comfortable. It would be nice to actually see the same mother more than once (if we do it is just luck)." This does not assist with the development of a relationship.

In some cases there are two nurses at each group session, which allows one nurse to be involved in the group activities and the second nurse to do one-on-one follow-up with the participants. The role of the nurse in the group settings is to provide structured educational presentation and to identify and participate in educational opportunities related to the conversations that occur and to take best advantage of "teachable moments" that arise. While one nurse is involved with the group, the other nurse is available to talk with program participants privately. This allows women to discuss confidential issues that they may think about as a result of information that is presented or as a result of events in their lives. In group settings in which two nursing staff are present, these opportunities are more easily and more naturally created. When observing these sessions, I determined that the one-on-one meetings are a subtle but intentional part of the process. Women move in and out of the group for the private conversations, barely noticed by the other group members.

In one session that was observed, a woman was dealing with severe postpartum depression and took almost all of the time with one of the nurses in that session. This nurse was able to link the woman with resources to assist her. While this process was happening, the group activities proceeded as usual. Without the presence of two nurses on this occasion, programming for the group or for the woman in question would have been more difficult.

Other staff members participate in program presentations as well. Project assistants from the Public Health Centres help with setting up rooms and preparation of

food and other supplies for the group activities. These staff members often have university-level education, usually have excellent computer skills, and are creative. They support a variety of programs at the Public Health Centres and are accustomed to working closely with clients and nursing staff. Project assistants in many sites appear to have comfortable relationships with women who participate in the Health for Two program, with the program content and process. Some sites have staff from community agencies participate as part of the group program. They spend time talking with the women and provide childcare in some cases.

Older children are frequently present at the program. Because some of the programs do not discourage women from coming to the program after their babies are over two months of age, many of the sessions also have babies up to one year of age. At one site older children are in a separate supervised play area. Most of the time they play in the same room in which the group occurs. Toys are provided, and parents, nursing students, or staff members supervise the children. Volunteers sometimes provide supervision of older children and assistance with other program activities. At three sites these volunteers were graduates of the Health for Two program. These volunteers are paid an honorarium through the Health for Two program funding. At one site the volunteer had taken training in the Nobody's Perfect parenting program and was delivering sessions to the women in the program. Although this was not a formalized mentoring program, I observed the confidence that the women had developed. Peer mentoring programs have been successful in working with disadvantaged women (Kistin et al., 1994; Lapierre et al., 1995; McFarlane & Fehir, 1994).

4.3 Planned Program

Because the program is delivered in a variety of ways and some staff members have felt that the program should be client driven and responsive, the formal or planned part of the program varies from site to site. There are some structured elements that can be used to develop the planned part of the program. The formal elements of the program as they were observed can be classified into six categories: milk coupons, program binders, educational content, crafts, food and telephone calls.

4.3.1 Milk Coupons

The first element of the program that is consistent across the region is the milk coupons. These are a constant, tangible part of the program that each client is able to access. They provide some nutrition for the woman and may provide an incentive to attract women to the program. The milk coupons are distributed in various ways, but whether women are seen in a group setting or one-on-one, the distribution of milk coupons creates an opportunity for the nurse to interact directly with the client. This may not always contribute to the relationship with the client. When the coupons are distributed during a group session, it appeared to be more difficult for clients to ask for individual time with the nurse in order to discuss more confidential issues. When the on-call nurse distributes coupons, access to the coupons for women who may not be able to attend at the regularly established group times is ensured.

4.3.2 Program Binders

The second formal element of the program is the Health for Two program binder (Capital Health, 2000), which was developed when the program started in 1992 and was revised in 2000. It can provide a framework for group sessions as well as for individual

contacts with pregnant women in the program. Each woman is provided with a binder to take home, but making an assumption that each woman reads, understands, and changes behaviour based on information contained in the binder would be a less-than-firm basis for program delivery. During six sessions, when nurses referred to sections in the binder that were applicable to the topics being discussed in the educational part of the program, many women stated that they were unfamiliar with the material. In three sessions women for whom English is a second language were present. Their ability to comprehend was limited. Although there are pictures in the binders, it is doubtful that they would have a comprehensive understanding of the material. During the observation sessions, the content from the binder was used in a variety of ways, described below. It is not obvious or clear that it was used in every situation.

4.3.3 Educational Content

The third category into which the formal part of the program falls is educational content. The educational sessions that were observed included a range of subjects. Some were centred on the pregnancy, and others related to the babies. Still others encompassed both of these elements. At one site a formal presentation was provided on safety tips and issues for children at Halloween. This particular session was interactive and practical and was supported by information that was handed out for take-home reference. One presentation that was observed at another site related to warning signs of problems during pregnancy and labour and when caring for the baby. This session was developed using flip charts, small-group work, and a great deal of participation by the women in the group. The discussion was lively. Afterward, the nurse reviewed the work done by the individual groups with the whole group and ensured that the issues identified were

appropriate and presented in a way that would be helpful. The nurse then pointed out where the information was located in the Health for Two binder and asked women to focus on the emergency list that is located in the binder. She provided suggestions as to ways that that list could be used to deal with warning signs that had been identified. This appeared to be a useful strategy to reinforce the material in the program binders without being too structured.

Another example of structured educational content was a group in which the topic was weight gain and nutrition in pregnancy. In this session a game called the Weight Gain Game was used to discuss the issue of weight gain during pregnancy. The game sheet was handed out to all group members and completed by them. It was then discussed with the group. Later, staff members pointed out that this game and supporting information were in the program binder. The issues of food costs and food security were a part of this program and were in fact a part of many of the group and individual sessions that were observed.

There were other educational sessions which were not observed, but which were described and discussed by clients and nursing staff during the sessions that were observed. Firefighters and police officers conducted sessions on fire safety and personal safety. These sessions were planned with two purposes. One of the goals was education, and an additional goal was an opportunity to link to other community resources. Other educational sessions in the group format included topics such as birth control, breastfeeding, labour preparation, and parenting.

In places where the program is delivered through one-on-one sessions, individual staff members were observed using the binder as an educational tool in addition to

responding to issues identified by clients. Some conversations with clients were skillfully directed to bring out these issues when clients did not initiate these conversations themselves

4.3.4 Crafts

Crafts are included as part of the formal program at several of the group sites. At two sites nurses and other program staff members assist with the craft activity. At one other site an outside expert was brought in to demonstrate quilt tying. In all cases supplies had purchased with the Health for Two network budget, which comes from the core funding provided by Health Canada. While the outside craft expert was working with the women, the nurse was able to circulate among the group members to discuss health-related issues.

4.3.5 Food

Food is the fifth identified part of the formal program. At a number of sites it appears to be a key incentive for gathering. At these sites considerable effort goes into purchasing and preparing the food. The food provides a strategic way of creating an informal atmosphere in which women are able to talk with one another. If the nurse is part of this activity, it provides an additional opportunity for education related to issues identified by clients. In such an environment there is a possibility that all program participants can benefit from the questions and answers.

At sites where snacks were served, in every case the food was nutritious, economical, and part of the discussion in the session related to these factors. Yogurt, fruit and vegetables, and bagels were some examples of food that was served. The food was purchased on sale and the cost of the items was discussed with the group. At one site

part of the formal program was about nutrition, and the participants prepared a salad. The recipe was provided, and the cost of ingredients was listed and reviewed with the women in the group. They were asked to identify the food groups that were contained in the recipe. The women prepared components for the meal in small groups and then put them together. This became a social activity as well as an educational opportunity. In addition, this activity provided a nutritious snack for group participants and other family members who were in attendance. Ingredients for the snack and lunch are provided through funding for Health for Two.

4.3.6 Telephone Calls

Telephone calls were used by a number of the nurses for several reasons. They called women to follow up on referrals that were made. They contacted women to remind them of sessions that were coming up. In several of the sites, telephone reminders were a regular part of the program. Telephone conversations create another opportunity for one-on-one discussion. The calls provide a chance for women to ask questions and are another way to build on established relationships. It is a way of saying to the woman that she is important. Not all of the women in this program have telephones, and this makes contact difficult if women drop out of the program and nurses are not able to make home visits to follow up.

4.4 Informal Interactions

One of the key themes arising from the observations of the Health for Two program is the relationships that are evident. These relationships are apparent between the staff members and the clients and among clients. In several of the groups, members attend for more than a year. During this time they are pregnant, giving birth, and

adjusting to the presence of the child in their lives. When other women in the group are experiencing the same things and often dealing with similar challenges, it is apparent that bonds develop through these common experiences. This provides social support from other women and is combined with health information from nursing staff. It is also apparent that group participants attend regularly when they obtain benefit from the program. The relationships that women develop appear to be a key benefit.

Although some groups have a structured program, as previously described, in each one there is an atmosphere that is sensitive to client needs and issues. In some of the groups and in every one-on-one session, the first things to be addressed are whatever concerns the clients identify. During the sessions that were observed, this resulted in some interesting topics being identified and discussed. The nature of the issues indicates that some of the women are very comfortable discussing sensitive topics. Some of the subjects that were identified and discussed in these sessions included separation and child custody, poverty, child welfare, sexual health issues, and mental health concerns. In addition, less controversial issues such as dental care, child development, alternative medicine, and prenatal classes were talked about.

Although opportunities for education and referral present themselves in the formal part of the program, other opportunities emerge during the informal interactions. In these discussions people may have misinformation as well as things that concern them. If the nurse misses the opportunities to address these "touchy" issues, the chance may not come again. Each time a discussion occurs, the knowledge and comfort of the group members increases, and the relationship is enhanced. The discussion of personal subjects creates enhanced intimacy in the relationship, but it also creates expectations from the client of

the professional. This means that nursing staff need to ensure that they are well informed or that they know where to get information when they unsure of the response.

4.5 Language of the Program

4.5.1 Group Sessions

Nursing staff appeared to take their lead from program participants in regard to topics that are discussed. In most cases the comfort of program participants determined the language level that was used in program delivery. Although there was some formal program in all of the sessions observed, the language was informal and the tone was responsive. In some cases the women in the program appeared to be well educated. They were articulate and well spoken. In other cases, the women communicated at a more basic level. Some were reticent to initiate conversation or questions. Others had no hesitation at all. In several program sites, it was clear that women spoke English as a second language. For some of these women it was important to use visual aids. In some limited cases interpreters and cultural brokers were used to assist with language and cultural sensitivity.

In two different groups one individual was developmentally delayed. These women both lived in group-home situations. Although they did not verbally participate in the program, in both instances they paid attention to what happened in the program. The fact that they were regular attendees demonstrates that they received some benefit from program proceedings. Although they spoke very little with other group members, they did talk with the nursing staff. These discussions occurred in clear and deliberate speech. Issues were discussed simply, and staff clarified to ensure understanding.

In one session women were offered instruction on cardiopulmonary resuscitation. Most members of the group participated. The language of the instruction was somewhat technical. Topics covered in this presentation included resuscitation of adults and children. There was plenty of opportunity for the women to practice with resuscitation dolls. The women were particularly engaged when the discussion switched to infant resuscitation. The activity of practicing what they had learned stimulated conversation between group members.

There was a great deal of informal interaction and discussion among group participants in many of the groups. Women asked questions about pregnancy and childbirth in their own words. They described things that they were feeling or things that they had heard about the experience of others. Nurses demonstrated skill at getting to the heart of the issues and providing correct information to the women without creating embarrassment. This appeared to create an increased comfort level for the women, and they asked more questions. Laughter among the group members was common.

In larger sessions there appeared to be greater diversity of educational level among the participants. In these groups it appeared to be more challenging to ensure that all group members understood what was being discussed and stayed engaged. Nursing staff appeared to be able to make adjustments in communication style so that every woman benefited. Women participated in group activities and discussions, but, with the exception of one group, most of the very personal issues were discussed when they were seeing the nurse one-on-one.

4.5.2 One-on-One Sessions

In four of the program sessions that were observed, the program was delivered in one-on-one sessions. As previously described, these occurred in clinic rooms or on home visits. In these sessions, the client drove the language of the program and the issues that were discussed. The women tended to get to the point quickly and talk freely. Although more personal issues were discussed in the group settings, these appeared to be much more easily identified and discussed in a more intimate setting.

Chapter 5

Phase Two: Survey Questionnaire Results

5.1 Respondents

All of the respondents to the questionnaire were nursing staff working in the area of community health nursing. All nurses working in this division of Capital Health are baccalaureate prepared. Table 5.1 provides demographic data for the respondents to the questionnaire.

Table 5.1

Demographic Characteristics of Respondents to Questionnaires

Years of experience in community health nursing	Number of participants
0 – 2	3
2 – 4	6
5 – 10	7
>10	5
	Total: 21
Number of years delivering Health for Two	**Number of participants**
1	10
2	3
3 or more	8
	Total: 21
Frequency of delivery of the Health for Two program	**Number of participants**
Once per week	16
Twice per week	3
More than twice per week	2
	Total: 21

Although the data were fairly evenly distributed over the ranges that were identified, more than two thirds of the respondents had more than two years' experience in community health nursing, and over half had more than four years' experience. This indicates that the majority of participating nurses were experienced in community health nursing. There were three individuals with less than two years of community health nursing experience.

Slightly less than half of the respondents (10/21) indicated that they had been delivering the Health for Two program for one year. Eight individuals who responded had delivered the program for more than three years. This response indicates that the majority of the respondents were familiar with the program material. This suggests that they would be in a good place to offer opinions on the program delivery and content.

Sixteen out of 21 respondents delivered the program once per week. Because the group programs are delivered once per week in most of the health centres and most of the one-on-one programs are delivered by each nurse one time per week, this response is consistent with current organizational practices and observational data.

5. 2 Issues

Table 5. 2 identifies the issues that were identified by respondents in reply to the first question and the number of individuals who identified each issue.

In all, 35 different topics were identified in the response to the question, *"What issues do you address with women who are clients of the Health for Two Program."* The rate of response to various topics ranged from 20/21 to 1/21. Although respondents identified many individual issues, one quotation describes where many nurses said they would begin:

Table 5.2

What Issues Do You Address With Women Who Are Clients of the Health for Two Program?

Issues	Participants (#/21)
▪ Nutrition	20
▪ Food security	12
▪ Labour and delivery preparation	11
▪ Violence	11
▪ Social Support	10
▪ Prenatal care	10
▪ Growth and development	8
▪ Referral to resources	8
▪ Prenatal classes	7
▪ Income	7
▪ Health issues	6
▪ Baby supplies	6
▪ Mental health/balance	6
▪ Smoking	6
▪ Housing	6
▪ Breastfeeding	5
▪ Substance abuse	4
▪ Weight gain/loss	4
▪ Cultural support/language	4
▪ Safety/fire safety	4
▪ Contraception	4
▪ Hospital tour	3
▪ Parenting	3
▪ Transportation	3
▪ Healthy beginnings program	3
▪ Postpartum depression	2
▪ Immunization	1
▪ Siblings	1
▪ Clothing	1
▪ Paternity	1
▪ Isolation	1
▪ Literacy	1
▪ Budgeting	1
▪ Spiritual health	1
▪ Dental health	1
▪ Exercise	1
▪ Prenatal testing	1

> First and foremost our goal is to address issues the clients have identified. If there are no overtly identified issues identified by the women attending, we will then resort to the nursing care plan to ensure that the key issues of nutrition and prenatal care are addressed on a regular basis. (two to four years' experience nursing, less than one year delivering Health for Two)

A majority of nurses responded that they would start by asking clients what they wanted to discuss, with probes such as, "What issues or concerns are you dealing with this week?" and "What questions do you have?" This demonstrates a client-focussed approach. The majority of nurses described starting with this perspective, then moving on to other issues that are important to address with women who are part of the target population. These women are pregnant and may be dealing with other issues related to poverty such as food security, housing, employment, and income security. These types of issues may take on increased significance when pregnancy is added to the equation of their lives. Dealing with these other issues may influence their ability to have a healthy pregnancy. These issues and other determinants of health are clearly a part of the program delivery in Health for Two. Although nurses did not refer to determinants collectively, many of the issues that were identified fit into a framework encompassed by the determinants of health.

The women in the program also may not have had good relationships with health professionals in the past. This may have occurred during previous pregnancies or during other encounters. This idea was supported by Sword (1999), who said that women do not access services during pregnancy for many reasons: "Lack of knowledge about available prenatal services, lack of perceived importance of or need for care, and negative attitudes towards health professionals and health services are additional barriers" (p. 1172). At times it is necessary to overcome the effect left by these previous events before new

connections to services can be made. This may make it challenging for them to identify issues and will require skill on the part of the nurse to facilitate disclosure of issues and provide assistance to access resources to deal with those issues.

After nurses address the issues that clients identify, they usually address health concerns first and explain the program and its various components. These components include bus tickets, milk coupons, vitamins, and the Health for Two binders. From that they move on to discussions about previous pregnancies and a discussion of other resources that are available for women depending on the issues they identify. These issues may be very comfortable for nurses to discuss with women and may be a way for the nurse to gain the confidence of the client. This will be the beginning of the relationship, which may allow the woman to disclose more personal information and problems. The following are broader categories of issues that were most frequently identified in questionnaire responses: nutrition, poverty, medical and health concerns, pregnancy specific issues, social support, and other issues.

5.2.1 Nutrition

The issue most commonly identified was nutrition (20/21). Other issues that are related to nutrition include food security (12/21) and weight gain/loss (4/21). The issue of nutrition is well supported in the Health for Two program binders and is supplemented by a cookbook and other handout resources. These clearly describe the foods a woman should eat in order to have a balanced diet. They emphasize the importance of healthy eating to the development of a healthy baby and the maintenance of health in the mother. The material that is provided to mothers in the program approaches the area of nutrition from a variety of different perspectives. One issue that is emphasized is the topic of

weight gain in pregnancy and what is normal weight gain. This topic is approached from the perspective of what is healthy and what contributes to the total weight gain in pregnancy. The third issue related to nutrition is food security, which relates to the ability of the woman to obtain food. Knowing what type of food to eat is one thing; being able to afford to buy nutritious food is quite another.

Discussing the issue of food security with a woman can lead to a richer assessment of the woman's economic situation. This information can identify where the woman may need support to improve access to sufficient and nutritious food through resources in the community. This may result in referral to other community resources such as food banks, collective kitchens, and food cooperatives or to an agency that can help with additional income supports if that is appropriate. Knowing the availability of these resources as well as the way they work will help the nurse to ensure that the referral is appropriate. Follow-up with the woman at subsequent visits is important. Follow-up with the woman by telephone prior to the next visit may be important as well, if it is feasible. These issues were identified in the response to surveys, and the sessions using these tools were part of the observation phase of this study.

5.2.2 Poverty

Although the issue of food security is related to nutrition, it also relates to poverty. Other subjects that were identified that relate to poverty are housing, income, and transportation. One person mentioned budgeting. The target population for this program is low-income pregnant women. All of these responses indicate that the nursing staff are aware that it is important to discuss income with these women and that there are a variety of topics that will lead to further revelation of income status. Any of these topics

may also require referral to outside resources. The issue of transportation can be alleviated somewhat through the use of bus tickets that are provided through the program funds. Milk coupons also provide nutritional supplements to women who may have inadequate resources to purchase food. For women who have very low incomes, none of the supplementary supplies that are provided through the program will be sufficient. For these women it will be necessary to explore other community options. Knowledge of other community programs that deal with such issues is critical for the nurse providing service to these women.

5.2.3 Medical and Health Concerns

Many of the issues identified by nurses were medical or of a health nature. Six out of 21 responses identified "health issues" as something they would discuss. Other issues in this category that were identified were dental health and immunization. It is natural to expect that nurses have more knowledge and expertise on these topics. In fact, women may very well ask questions related to medical issues more frequently when attending a prenatal program in a health facility. Sharing their knowledge of pregnancy in all of its stages and other medical issues and programs provides a natural way for nursing staff to connect with women. By beginning with these topics, which can be discussed safely and easily, the nurse may forge a relationship that will lead to a foundation for the discussion of topics with which they are less comfortable.

5.2.4 Pregnancy Specific Issues

As with general health concerns, pregnancy health issues are a comfortable area of discussion for nursing staff to engage with clients. Many may not have the experience to provide the best information on this topic because they provide focussed practice and

generally do not teach prenatal classes. Nurses who have significant years of experience may have taught prenatal classes in the past and may be very comfortable providing this information. Others may refer women to prenatal classes. In fact, seven identified that they would talk about prenatal classes. One nurse with 5 to 10 years of nursing experience stated that one of the issues that she would discuss with the women was prenatal/breastfeeding classes, and she would "ensure they are enrolled if they want to be; if not, facilitate one-on-one prenatal teaching by us." This individual had been delivering the program for more than three years. Although it would not be inappropriate to ask the women about prenatal classes, often women who are disadvantaged do not feel comfortable in mainstream prenatal classes. This was one of the reasons that the Health for Two program was initiated.

Other pregnancy-related health issues include prenatal care, breastfeeding, contraception, the Healthy Beginnings Program (the postnatal home-visitation program), postpartum depression, exercise, and prenatal testing.

5.2.5 Social Support

A variety of the topics identified by nursing staff related to the social circumstances of the women. The number one issue in this category that was identified by nursing staff was social support. Nearly all of the respondents (17) mentioned the importance of social support. Questions that nurses asked to identify whether women had social support included those about family, friends, partners, and relationships. One nurse suggested asking about support systems: "Partner, family, friends—what are these relationships like for her (supportive, abusive, unhealthy)?" Many included references to abuse in relation to those relationships. Half of the nurses identified the topic of violence

separately. Most of the nurses who identified the issue of violence as something that they would discuss had more than five years' community health nursing experience (8/21). Five out of 11 had more than 10 years' community health nursing experience.

One-third (6) of the nurses mentioned mental health and stress as an issue that they would want to address with their clients in this program. Respondents identified the topics of substance abuse (4) and smoking (6) less frequently. These issues can be captured under the heading of social issues, but they certainly have medical or health implications as well, particularly during pregnancy.

> Pregnancy presents a window of opportunity for motivating women to stop their abuse of substances. To do so, however, nurses must be armed with the knowledge and information necessary to screen and identify women who abuse substances while pregnant. They also must maintain a nonjudgmental, nonpunitive attitude. It is with this knowledge and understanding that nurses are most likely to exhibit positive behaviours and attitudes while they provide support for women who are in need of substance abuse treatment. (Selleck & Redding, 1998, p. 70).

5.2.6 Other Comments on the Responses to Issues

Some of the responses were brief and very general in nature. Others were detailed and specific. The more detailed and specific responses mentioned the use of some of the resources that are provided by the program. These resources include the Health for Two Women's Record, which includes a list of issues that could be addressed with women. This form includes statistical information that is collected for Health Canada regarding the Canadian Prenatal Nutrition Program. It is generally used when women begin the program and at each subsequent visit. This record identifies 13 issues: violence/abuse, food security, smoking, alcohol, drugs, weight gain/loss, healthy diet, needs doctor, health issues, support/isolation, housing, baby supplies, baby care/feeding, and

transportation. It does not, however, provide any information about how to address these issues with women. Some of the issues are easy to address; others are far more difficult.

Another program resource that was mentioned by nursing staff was the Health for Two binders that are handed out to women in the program. This binder identifies issues related to healthy eating, violence and abuse, alcohol, smoking, street drugs, over-the-counter and prescription drugs, herbs and natural remedies, sexually transmitted diseases, and safer sex. The majority of the binder is devoted to growth and development of the fetus and the woman at various stages of pregnancy. Two of the nurses identified the binder as something that they would use as a guide when working with women in the Health for Two program. The binder identifies issues but does not necessarily provide strategies and tools to assist with identification, discussion, or intervention in relation to these issues.

One final tool that was mentioned in the response to this question was the care map that was developed for use with Health for Two clients. It was introduced about halfway through the data collection in this study but was mentioned by only two nurses. This care map would provide a roadmap for nurses to use when seeing women, which would help nurses to know "where" to go in their discussions with women; it would not necessarily help them know "how" to get there. Additional information about the process of counselling women, particularly with more sensitive issues, would ensure that it happens.

5.3. Goals

Table 5.3 lists the responses to the question about what goals the nurses have in mind when they are seeing women in Health for Two. Nurses described what they are trying to achieve in the program in a variety of ways. One nurse described it this way:

> Help women to make healthy choices for themselves, their babies and their families (from the mission statement); help women connect to resources in the community (i.e., food, clothing, counselling); support women however they need to be supported, to empower them. (5 to 10 years' experience, more than three years with the program)

Table 5.3

What Are You Trying to Achieve When You Are Delivering the Health for Two Program?

5.3.1 – Improved pregnancy outcomes
• Safe delivery of baby • Healthy baby • Healthy babe / healthy mom • Healthier pregnancy • Healthy as possible pregnancy • Increase health for mom and babe • Healthy babes • Healthy babe
5.3.2. Access to Health Services and Other Resources
• Help woman see health centre as a resource • Accessibility to health support, referral • Entry to health system • Resources • Increase access to resources • Increased contact between client and health care • Referral to resources • Resources • Increased comfort with accessing services
5.3.3. – Choices—Empowerment
• Options for women • Empowerment • Effect change in lives • Shortening gap between reality and possibility • Help to effect change • Informed choices • Healthy choices • Improving lifestyles/habits • Empowering women with knowledge regarding pregnancy • Guide healthy choices for selves, babe and family

(table continues)

5.3.4. – Relationships, support

- Develop a relationship with client
- Help clients develop a relationship with each other
- Relationship
- Increased support
- Rapport
- Assessing needs
- Meet clients needs

5.3.5-Knowledge, skills

- Increased knowledge (3)
- Nutrition
- Providing women with skills
- Education
- Increased awareness

The words they used to identify their goals for the program facilitated placing them in several categories. Although they are stated in response to the question about what nurses are trying to achieve, some of the descriptions really identify strategies that are used to reach the outcomes.

5.3.1 Improved Pregnancy Outcomes

It is not surprising that nurses described good birth outcomes as something they were trying to achieve. Some spoke of the health of mom and babe. Examples are "healthy mom, healthy babe," "improved health both physically and emotionally for mom and baby," "as healthy as possible pregnancy with a healthy baby." Other responses referred to the baby as the focus of the program. "Ultimate safe delivery of term babe," "healthy baby," "produce a healthy, good weight baby." Still others referred to the pregnancy as the focus of the efforts of the program nurses. They said that their goals were "healthier pregnancies," "creation of a better environment for the pregnancy to

improve the outcome," and "as healthy as possible pregnancy." The issue of healthy pregnancy relates to healthy child development.

5.3.2 Access to Health Services and Other Resources

Nurses see themselves as a point of referral to other resources that would be useful to women as they deal with the issues surrounding their pregnancies and their lives. One of the nurses stated that she wants to "increase knowledge and access to resources to assist in obtaining a healthier pregnancy and birth outcome." Another nurse affirmed that she wants to "link them to other services as appropriate to improve their situation as best we can. Do what we can to ensure a healthy baby and a positive prenatal experience."

5.3.3 Choices—Empowerment

Nurses identify that they want to use their involvement with women in the program to provide them with the ability to make choices. Through the issues that were identified earlier, it is clear that the choices may be in a variety of areas of their lives. As one nurse put it, "provide women with options, empowerment to affect change in their lives" (five to ten years experience, less than one year with the program). Another says it this way, "to help them make informed choices" (five to ten years experience, more than three years with the program). Another response referred to knowledge about pregnancy as being an empowering factor "empowering women with the increased knowledge regarding healthy pregnancy" (two to four years experience, two years with the program).

5.3.4 Relationships Social Support

This theme persists across all of the responses to each question. All nurses described intending to develop relationships with the clients, and many identified a desire to support the clients in developing relationships with each other. In most cases the way the relationship is described as an achievement really refers to that relationship as a way to help women develop skills, gain knowledge, and have a healthy pregnancy. Through these relationships nurses are able to learn about issues with which women are dealing and to assist them to gain access to knowledge and resources that will help them. In addition, these relationships with nurses and with other women may be a way for women to develop confidence, which will assist them in self-advocacy and advocacy for their families.

One nurse stated that she was trying to "develop a relationship with the client so she feels/sees the nurse/health centre as a resource for help and information and have the clients develop support systems with each other." This demonstrates the fact that nurses are using the development of relationships with women to help the women to connect with health services, which may help to alleviate circumstances in which women find themselves. Alleviation of these circumstances may ensure a healthier pregnancy. Another nurse stated that what she was trying to achieve was to

> meet the needs of each client. Some need a person to talk to about a variety of concerns/fears, some want specific information about pregnancy and childbirth. We'd like those women to connect with each other and share their experiences, know they have something to contribute. Give them a sense of safety—anything is open for discussion, all questions are good questions. Build a relationship based on trust and respect between clients and nurses that will continue even after the birth. (two to four years' community nursing experience, 1 year delivering Health for Two, delivers program twice per week)

One nurse with more than 10 years' experience in community health nursing and two years' experience with Health for Two said:

> To support mom and baby in pregnancy to have a full term, good birth weight baby. Mom feels supported for herself and the baby after the baby's birth and up to a year. Hopefully after that time they will feel secure enough to try other community supports and make community friends.

Once again this description refers to the relationship that is developed in the program to build confidence in women so that they will be able to access other services, resources, and relationships when they are finished with Health for Two.

5.3.5 Knowledge, Skills

Responses to the question about what nurses were trying to achieve when delivering the Health for Two program included references to building the relationship with women. The relationship provides a basis for their practice. One nurse described wanting to provide women with information and help them build skills to "shorten the gap between reality (poverty, low expectations of employment, and relationships) and what is possible (education, meaningful employment, healthy relationships, healthy parenting, improved nutrition, and safety)." One nurse connected the provision of knowledge to women as a way of increasing control that women have over their lives. She described "empowering women with increased knowledge about healthy pregnancy." Another nurse with 5 to 10 years' experience in community health nursing and more than three years' experience with Health for Two described using education and information as a way of helping women to gain increased control over their lives:

> I am trying to increase women's knowledge about their bodies and the developing fetus to help them make informed choices to ensure the healthiest possible birth outcome. I am also trying to help women recognize and make healthier choices regarding their own life outside the event of pregnancy.

The concepts and ideas identified in the last quotation are stated in other ways. One nurse stated that she was "trying to get mom to make good decisions concerning her health and the health of her family. A mother with good support can get through just about anything." Another stated that she wants to "provide women with options-empowerment to effect change in their lives."

Some of these quotations are not really specific about how it would be possible to go about supporting women to make healthier choices. Personal health practices are influenced strongly by social environments in which people live.

5.4 Strategies

Table 5.4 shows the responses to the question about strategies that nurses use to accomplish their goals when working with women in the program.

Table 5.4

What Strategies Do You Use When Delivering the Health for Two Program? (How Do You Do What You Want to Do?)

Strategy	Participants
▪ One-on-one conversations	12
▪ Identify client's needs	9
▪ Use films	6
▪ Round table discussions	5
▪ Phone calls	5
▪ Warm, friendly, receptive	5
▪ Non-judgmental	5
▪ Referrals	5
▪ Home visits	4
▪ Display books	3
▪ Information sharing with other health centres	3
▪ Brief information sessions / relevant	3
▪ Take cues from client	3
▪ Develop trusting relationships	3
▪ Use HF2 binder	3
▪ Information sharing with other team members	2
▪ Questions and answers	2

Strategy	Participants
▪ Crafts to engage group members	2
▪ Continuity of staff	2
▪ Inservice education	2
▪ Charts, pictures	2
▪ Build on language used by client	2
▪ Group activities	2
▪ Listening (active listening)	2
▪ Pamphlets	2
▪ Social support of group	2
▪ Presentation of accurate information	1
▪ Parenting programs	1
▪ Common sense suggestions	1
▪ Truthfulness	1
▪ Avoid films	1
	(table continues)
▪ Support from supervisor	1
▪ Project Assistant support	1
▪ Use creative ways to teach	1
▪ Be available	1
▪ Guidance	1
▪ Education	1
▪ Advocacy	1
▪ Specific appointments	1
▪ Flexible	1
▪ Coupons	1
▪ Vitamins	1
▪ Bus tickets	1
▪ Physician referral	1
▪ Ask directly	1
▪ Brain storming among nurses	1
▪ Develop discussion topics, resources	1
▪ Ask for feedback from clients	1
• Referrals Food bank	1
• Referrals Early Head Start	1

The strategies or "the way people do what they do" provided a list of more than 50 items. These strategies can be categorized in a variety of ways as well.

5.4.1 Structure of the Program

There are several structured pieces available in the program. These were identified as part of the strategies that were used to implement the program. One of these is the Health for Two binders. One nurse explained that she can "utilize the prenatal binder to guide discussions and encourage clients' use of the binder."

The structure of the program relates not only to program materials but also to the method of delivery. A number of different delivery methods are noted within the city and have been identified by nurses responding to the questionnaire. One method that was identified is providing one-on-one counselling, and a second common method is arranging group activities. In groups,

> the most important strategy is to make the client feel welcome and to help them integrate into the group. This ensures a social connection is made, thus ensuring social support. This in turn leads to the clients feeling comfortable enough to ask questions and contribute to the group process and thereby learn more effectively. Social learning is very effective. Any information must be presented at an appropriate level due to the range of clients we deal with (university to Grades 8 comprehension levels). Lastly, we try to vary our presentations following the nursing care plan and identified client needs. This ensures that we cover as many of the topics as possible, as needed by our group (two to four years experience, less than one year in the program).

Another strategy identified by the nurses is the use of telephone calls. Through the use of one-on-one discussions, either face to face or on the telephone, issues can be identified that are specific to the women, and "referrals can be made to outside agencies." Nurses described the use of group sessions with associated opportunity for one-on-one contact on the same day. "We provide a weekly drop-in for Health for Two moms where we discuss the different women's needs as they arise-opportunity for group conversation and one-on-one." Another respondent mentioned "one-to-one conversations, with clients

identifying their needs, and round-table discussions where accurate information is provided about issues discussed by women."

Home visiting is also described as a strategy that is useful for reaching women who are housebound or for being able to better assess the circumstances in which women live. One nurse remarked that she used milk coupons, vitamins, and bus tickets as a strategy to engage women and stimulate discussion related to nutrition, medical care, and transportation as it relates to income security. This nurse identified these program resources as useful in starting these discussions.

Another strategy that was identified was using informal discussion and a craft activity to relax and engage the women at a group session.

5.4.2 Consultation With Colleagues

Some of the nurses responding to the questionnaire affirmed that their colleagues in their own health centres and other nurses who deliver the program in other sites are a source of support and knowledge about program content. One stated that her strategies included "consulting with other health centres to gain ideas, regular brainstorming sessions among Health for Two nurses to develop topics and resources to be used." Other nurses are always trying to "increase their own knowledge base in the area" by "accessing and presenting inservices for ourselves" and attending interagency meetings.

5.4.3 Relationships

Many nurses identified the developing relationships as a strategy they use to deliver Health for Two. They do this by starting "where the client is" and by making the women feel comfortable. By "always asking if women have questions/concerns at the beginning of a session," they hope to assist women to identify their needs and to help

them to meet those needs through the program. One nurse responded that the program must be "client-centred and flexible while addressing the mother's questions and issues." One nurse expressed a desire to "try and gain their confidence." Another one advocated "building a relationship or getting to know the woman and what is going on in her life." This same individual mentioned that social support is provided by the group sessions meeting once per week. This helps women to "build relationships with other mothers (many friendships have continued outside the group)." To facilitate the development of these relationships, nurses supported having a "flexible, open-door policy."

To build on these relationships, nurses stressed the importance of a "nonjudgmental attitude," "supportive listening," and "just talking." One nurse stated that "an extremely nonjudgmental, open, caring attitude is likely the most important strategy [for me]." Often, the goal of this relationship building is "trying to get them to think about changes they need to make." Using this relationship, nurses can often ask questions of the women to try to probe for issues that may not have been addressed spontaneously by the women. Another nurse described the importance of attitude and continuity of elements that support the building of relationships upon which to base practice: "Provide a nonjudgmental environment, warm, friendly, receptive to concerns; common sense suggestions/ideas to problems presented in a warm but truthful manner. Provide continuity in staff (same nurses run the program, not a different person each week)."

Other types of relationships referred to in this section are the relationships that women have with their partners. One nurse stated, "Sometimes you have to ask directly, 'Is there a father involved? How does he feel about the pregnancy? Has his behaviour

toward you changed—any violence or abuse?'"(5 to 10 years' experience, more than three in the program).

5.4.4 Educational Content

Providing educational sessions and material is a core strategy of this program. Some use educational information provided in the prenatal binders and encourage the women to use the binders that they are given as well. Not only the content of the sessions is important, but also the way the content is presented. Nurses spoke to this aspect of the program and described the way that they presented topics. One stated that they would "keep information sessions brief (ten minutes maximum) and relevant to moms." Another nurse stated that educational support was important, and the way to provide it is "giving information but drawing on their own experience." Nurses stressed that information is most effective when it is relevant to the women's own situations. The strategy that is used for presenting the educational content "depends on the client," but "try to use creative ways to teach information."

Various tools and supports are available and used to deliver educational content. One nurse described using "books, pictures, videos, conversation, question-and-answer sessions, and food diaries." Another nurse echoed those and added, "charts, handouts, and the Health for Two manual."

5.4.5 Referrals

Many nurses identified referrals as a strategy that they use when delivering the Health for Two program. One nurse referred to "appropriate programs/services in Capital Health and the community." To facilitate these referrals, nurses identify the need to

develop "close relationships with community partners—contacting them for referrals, resources, and information."

5.5 Indicators of Success

Table 5.5 identifies the responses to the question about how nurses measure success in the program. Two of the main indicators of success identified by nursing staff are consistent attendance at meetings and verbal feedback from the participants. One nurse stated:

> Feedback from our clients. Many openly state that this group is exactly what they need. They get so much out of the discussions. Success is shown in client participation. We reflect on our sessions with each other as colleagues to judge our effectiveness as a team.

In responding to the question about how you know if you have been successful, one response was:

> Good question. We have tried to be very careful and try to really look at the women's individual needs and follow her agenda. We have done evaluations (quick written evaluations) of the group to see if we are meeting the needs, what can we do better, what else would women like to see addressed. I will consistently just ask, "Is this helping you? If not, what will?" Try to be very client driven.

Table 5.5

How Do You Know if You Have Been Successful?

Successes	Participants: 21
▪ Attendance at group	12
▪ Feedback	10
▪ Change in behaviour	9
▪ Asks questions	7
▪ Trusting relationship	6
▪ Clients move on to other programs	4
▪ Good birth weight	4
▪ Babies good development	4
▪ Mom prepared	4
▪ Small successes	2
▪ Increased information sharing from client	2
▪ Relationship with group members	2
▪ Bonding	2
▪ Refers others	2
▪ Discussion with colleagues	2
▪ Use of birth control/delay of pregnancy	1
▪ Stay connected through postpartum depression	1
▪ Return with subsequent pregnancy	1
▪ Appropriate development expectations	1
▪ Follows through with suggestions	1

In responding to this question about how one knows that one is successful in a group setting, another respondent said, "It is quite evident when the group is successful. You can measure it by the responsiveness of the group on a particular day, as well as through their willingness to maintain that social contact and support on a weekly basis." The key measures identified in this comment are attendance and participation in the group. Other measures of success are categorized in the following way.

5.5.1 Health Outcomes

In a prenatal program for disadvantaged women, the goal is to support the woman to have a healthier pregnancy and birth outcome. Few of the factors that contribute to successful birth outcomes are within the control of a program such as Health for Two. One nurse replied that success may be measured by birth outcomes ("to the things we have control over"). One measure of success identified was the woman's weight gain (4/21). Other ways of naming success is "healthy babies, healthy women at the conclusion of birth," "babies have adequate birth weight" (4/21), "are full term," "relationships between mothers/babies are loving, developmental expectations are appropriate." Another indicator of success is "clients able to successfully use birth control and delay subsequent pregnancies."

Although it is not specifically a health outcome, one nurse indicated that she thought that she had been successful when a woman demonstrated "improved knowledge with respect to nutrition, pregnancy, labour and delivery, and baby care." Although knowledge of issues does not always change health outcomes, it is a beginning.

with respect to nutrition, pregnancy, labour and delivery, and baby care." Although knowledge of issues does not always change health outcomes, it is a beginning.

5.5.2 Program Attendance

Because this group of women may have competing demands for their time and energy, they often find it difficult to make it to appointments or scheduled activities. Therefore, if women attend the program regularly, it is considered an indication of success. It is also an indication that women are getting something from the program if they attend regularly. Nurses mentioned that they feel that the program is successful if "moms return for more visits with this pregnancy and with other pregnancies; they ask questions and feel comfortable—settling in to talk, smile." In addition to their own attendance, women "refer friends and family to the program."

This element is related to the concept of relationship that has been identified in previous data. One nurse described it in this way: "Moms regularly attend; relationships between moms and facilitators are relaxed." This concept of relationship is reflected in the comments of one nurse who referred to "when a mom stops off at the health centre on her way home from the hospital to show off her baby (what an honour)." Another respondent commented, "They come back and ask for you if they have a problem with themselves or the baby." Another enthusiastic response was "Oh boy they come back. They have a healthy baby. It is so hard to evaluate and sometimes painfully slow. If they come back, though, you have a contact and another opportunity."

5.5.3 Mothers Access Service

Throughout their involvement with the Health for Two program, participants are made aware of resources and services that are available to them within the health system and within the community. Sometimes women are referred to these services. Other times they are merely made aware of them. If women access these services as a result of their involvement in the program, it is a positive indicator for nurses providing the program. Another resource that women may access is the ongoing "use of the nurse for questions and support," in addition to the more "mainstream use of community health services." Moms become "actively involved in programs such as Early Headstart, Classroom on Wheels, New Parents, and single parents support group." Another nurse observed that "women demonstrate increased confidence, evident through access to services, questions, and comments—stresses have decreased." Another sign of success is that "clients are able to move on to other programs." This indicates that women have developed confidence to leave the immediate security of the Health for Two group and to take part in other activities. Nurses feel that the program is successful if the women access other services such as physician appointments and prenatal classes.

5.5.4 Maternal Behaviour Change

Another indicator of success is maternal behaviour change. One nurse mentioned that even an "interest in positive life changes" is an indicator of success. Another described it as "evidence of change in a women's choices/lifestyle." A specific example is "when a mom goes back to school to upgrade so she can enroll in the social work program, or when a mom is trained to deliver the Books for Babies program for the Health for Two group." One other respondent stated, "When we see moms going out of

the program that have grown-perhaps more responsible, confident, and happy." Another respondent commented, "See some changes in lifestyle; e.g., stop smoking." One nurse described it this way: "Look for small successes, change in practice/behaviours—client more willing to share, admit to a trusting relationship—client actively seeks information and values input."

5.5.5 Feedback From Women

Feedback from women was the number one indicator of success. Most of this was informal verbal feedback; however, one nurse observed that "informal survey results" were an indicator for her. Other types of feedback include "thank you notes received from clients and feedback from the Healthy Young Families team members who visit clients postpartum." Two formal evaluations of the entire Health for Two Program were done in the past, and one nurse mentioned that accessing this evaluation would be helpful.

5.6. Ways to Make the Program Better

Table 5.6. lists the responses relating to what nurses thought would make them able to deliver a better and more comprehensive program. Most of the responses related to the goals, issues, and strategies that were identified in the previous questions. The responses can be categorized as follows.

5.6.1 Internal Resources

Several nurses identified that they wanted increased availability of transportation or increased funding to use to provide other forms of transportation for women. Currently bus tickets are provided through the program so women can attend appointments and

Table 5.6

What Would Help You to Deliver a More Comprehensive Program to Women in the Health for Two Program?

Resources	Participants
▪ Time	14
▪ Better orientation/more knowledge of issues	7
▪ Community resources	6
▪ Money	5
▪ Transportation help	4
▪ More continuity	4
▪ Home visits	3
▪ More follow-up	2
▪ Support from management	2
▪ Sharing with work of other providers	2
▪ Child care	2
▪ Parenting programs	2
▪ More structure	2
▪ Case finding	2
▪ Labour and delivery support – Doula	1
▪ Welfare liaison	1
▪ Social worker	1
▪ Mentorship training	1
▪ Training opportunities	1
▪ Case conferences	1
▪ Supplies on hand	1
▪ Understanding of structure of organization	1
▪ Food vouchers	1
▪ Resources	1

programs. As one nurse described it: "transportation issues are huge. Very few moms will take a bus with even two or three children, especially when it is cold."

Another resource that was identified as something that would improve the ability of nurses to deliver the program was "babysitting for preschoolers to reduce noise and chaos." In the observation sessions it was noticed that some sites were able to provide childcare in a variety of ways. The ability to share these ideas and strategies may help other sites do the same things.

Additional resource identified included "vouchers for emergency food as sometimes women come on a Friday afternoon and we must send them to the food bank and hope they are still open."

5.6.2 Time

Eleven nurses who responded to the questionnaire simply said one word: "time." Other comments about time included "more nurse time to organize and deliver the program with greater flexibility," "more time to prepare and to talk with moms one-on-one," and "ability to have home visits scheduled into the weekly clinic schedule." Another nurse brought up the issue of more time: "especially working in the recruitment area (newly pregnant women)." "We are still missing moms that could have benefited from the program." This is one of the factors that may be overlooked as nurses seek to keep women in the program for longer and longer times after delivery. One respondent commented in more detail on the issue of time:

> The most important aspect of delivery of the Health for Two program is developing a relationship with the women. This takes time. So more time to deliver the program. This would enable more contact with women in a variety of settings (health centre, in mom's home, or perhaps a group setting). Also the paperwork involved with keeping the statistics required by Health Canada is time consuming, so time needs to be allocated for that purpose. Finally, there needs to

> be more 'buy-in' from the organization that Health for Two is a valuable program deserving of adequate time and staffing. (5 to 10 years' community health nursing experience, more than three years delivering Health for Two)

Responses to other questions and a common theme throughout this data-collection process included the subject of relationships. This theme was also part of a statement made by another nurse in her response to the question about what would make the program better:

> More consistency with the same mothers so they got to know us and felt more comfortable. It would be nice to actually see the same mother more than once (sometimes we do, but it is just luck) so we could develop a relationship. These moms are usually shy or inexperienced in using the healthcare system, and it would be nice to develop a better rapport so they would gain trust in the system and the professionals that work in it.

This comment was made by a nurse with between 5 and 10 years' experience as a community health nurse who had been delivering the Health for Two program for more than three years, but who delivered the program less than once per week. In all likelihood this is a person who saw women in the Health for Two program when she was the nurse on call.

Another idea was to "extend funding for longer contact between nurse facilitators and moms postpartum so more health teaching, permanent healthful life choices occur." This same individual responded that it would be important to develop formalized linkages with other partner agencies as moms graduate from the program "so moms are not lost." The Health for Two program is designed to connect with women during the prenatal period and until the baby is two months of age. In several of the group sessions, moms remained in the group until their babies were one year of age. It was clear that many of these women needed support past the time when their babies were two months of age, but

the idea of using other community resources to provide that support may be a way of using the Health for Two resources in a more focussed way in the prenatal period.

One nurse responded to the issue by saying that "we have been fortunate to be given the time to do Health for Two, and other staff have fully supported what we are doing."

5.6.3 Education, Orientation, and Training

In this category, nurses asked for a variety of educational content and opportunities for training. One nurse identified "group facilitation workshops" and "an annual workshop of all network partners to share successes, failures, and learning experiences." Another referred to "more training opportunities to enhance community linkages and intervention skills." Still another nurse (with less than two years' experience) added that she would like to have "a more complete guide of some of the issues to cover for average pregnancy and delivery—an orientation like Healthy Beginnings. . . . We need a better way to make sure there is consistent care either with an individual or a team." One nurse who had between two and four years of community health nursing experience but less than a year's experience delivering the Health for Two program stated:

> As a relative newcomer to the program I would have and still would appreciate more concrete learning resources (updated ones) and program aids. Hopefully this would cut down the preparation time involved in searching through videos and other resources to ascertain whether they are relevant to our group. Also inservices on group dynamics and group work would be helpful. I think once a year we should have an inservice to present some new learning strategies/ideas to keep the program fresh. I am thinking along the lines of the nursing care plan that we received at the last workshop and the information we were able to exchange with other professionals who work with the Health for Two population.

The care map that was mentioned by this nurse was introduced about halfway through the data-collection period, but was mentioned by only one of the individuals responding to the questionnaire. One nurse stated that there should be "a more complete orientation to Health for Two—how to deliver, what services are available and the best ways to get information."

5.6.4. Community Resources

Knowledge and use of community resources were identified by a number of nurses throughout their responses to the questionnaire. They recommended using these resources during the time that women were pregnant and when they reach the cutoff point for the Health for Two program. Many nurses said that they would like to have better information about community resources and how to access them to ensure that "our clients get to appropriate resources and to help us counsel families."

5.6.5 Structure

The structure of the program may refer to variety of things. It may be whether the program is delivered in a group or one-on-one. It may also relate to whether there are consistent elements and topics that are covered by nurses delivering the program. Last, it may relate to the framework that is in place to support program delivery, which includes orientation, education, and supplies for the program. Many comments related to these issues: "We need a better way to make sure there is consistent care either with an individual or team; i.e., a small group of two or three nurses who case-conference regularly on the clients." One nurse with more than 10 years' experience stated that there should be "more structure within the program, defining goals." This same person also stated that there needed to be more flexibility to carry services off site. "One final thing:

having a constant supply of materials (milk coupons, intake sheets, binders, moms' books, bus tickets) to be able to deliver the complete program as designed. It is very frustrating to constantly be short of supplies." Another comment focussed on the ability of nursing staff to develop the skills of potential peer mentors from the program:

> Have formalized mentorship training for nurse facilitators so moms with potential leadership qualities and [who] are positive role models for other moms can have training as co-facilitators of the program Nobody's Perfect or Books for Babies. Then they can move toward leadership positions within the Health for Two system (formalize and universalize adequate honorariums for these positions).

Some responses referred to "having your own case load" and "group work providing health education in the prenatal as well as postnatal period." Others referred to "having regular meetings with nursing colleagues conducting similar programs at other sites." In summary, nurses generally felt that they needed more resources, more education, and more structure. They also identified a need to clarify who was leading this program.

Chapter 6

Conclusions and Recommendations

6.1 Conclusions

The intent of this research was to identify the practice of nurses delivering Health for Two. Health for Two is a program targeted at pregnant women living in poverty. Although it is one specific program, Health for Two is representative of the way many new health programs are currently funded. Targeted pots of money have become a standard way of funding in the public sector. Frequently, funding organizations identify a target population based on issues that are related to at-risk groups, including people living in poverty. In many cases it is important to be able to initiate programs quickly when funding becomes available. Information learned about the practice of nurses in this program may assist in supporting nursing practice with similar populations in the future.

Although it is important to look at how clients view programs, it is also important to elicit impressions that nurses have of their own practice. It was possible to observe elements of that practice during the observation sessions and to corroborate and supplement those observations with information that the nurses provided in response to the questionnaire. Neither one of these data-collection methods would have been sufficient on its own to provide the complete picture of nursing practice in Health for Two.

6.1.1 Relationship-Based Practice

The observed and described way that the practice unfolds in this program is relationship based. A Health for Two care plan (Capital Health, 2000) was developed and circulated in draft form in November of 2000. This plan stated explicitly that to achieve

outcomes in the Health for Two program, certain themes or principles should be part of it. "There should be relationship based practice focused on respect and a client centred approach with flexibility in practice which is needed to increase access to service for all women " (p. 2). Although most nursing staff did not identify this care map as something that they would use (2/21), they did describe and demonstrate a client-centred approach and relationship-based practice. Relationship-based practice has two components, the relationship and the practice.

6.1.1.1 Relationship

Figure 1 shows the relationship between the woman and the nurse at the centre of the model. This research project identified this relationship as the central theme of the program. If the relationship is the initial focus of the program and continues to be its foundation, the program can be responsive and flexible. It is clear from the survey responses that the nurses in the program develop relationships with clients. The majority of respondents (15/21) emphasized the need to create an environment for the program that supports a relationship with the woman. This is illustrated by the following quotations included in response to questions about goals, strategies, and ways to improve the program:

> Provide a non-judgmental environment, warm, friendly, receptive to concerns. (more than 10 years' experience, one year with the program)
>
> Any issues that are important to the client. (more than 10 years' experience, two years with the program)
>
> The most important aspect of delivery of the program is developing a relationship with the women; this takes time. (5 to 10 years' experience, more than three years with the program)
>
> Build a relationship based on trust and respect between clients and nurses that will continue even after birth. (two to four years' experience, one year with the program)

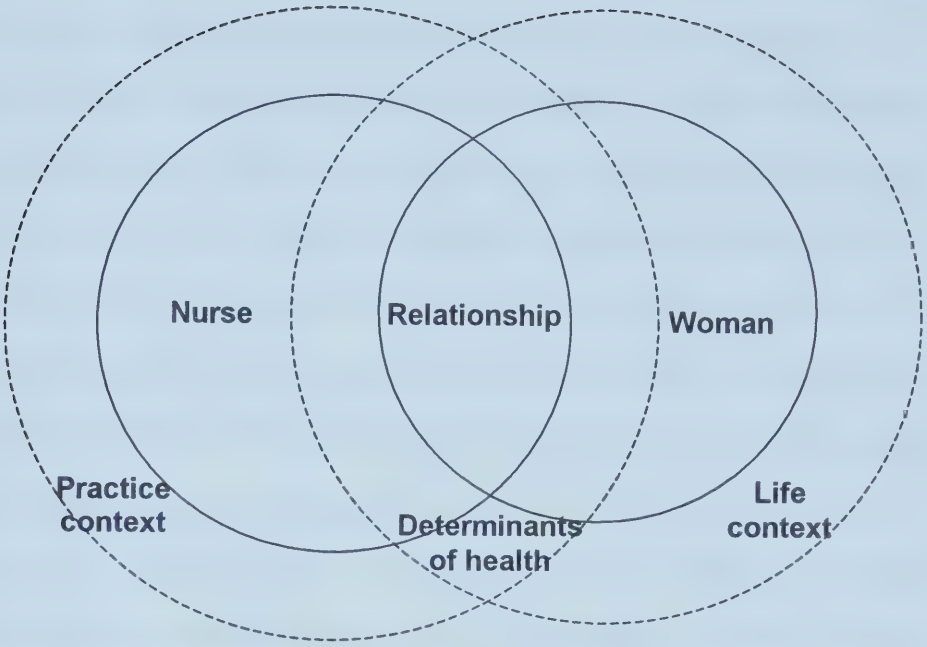

Figure 1. Relationship-based practice in Health for Two.

Build a relationship based on trust and respect between clients and nurses that will continue even after birth. (two to four years' experience, one year with the program)

In describing the relationship as a strategy, nurses said:

The most important strategy is to make the client feel welcome and help integrate them into the group, [and] this in turn leads to the clients' feeling comfortable enough to ask questions and contribute to the group process and thereby learn more effectively. (two to four years experience, less than one year with the program)

Having an extremely nonjudgmental, open, caring attitude is likely the most important strategy to me. (five to 10 years experience and three years with the program)

Develop a rapport with women to increase the women's comfort with accessing services. (two to four years experience, two years with program)

The last statement identifies the link between relationship and practice. Not only were these responses to the survey supportive of relationships, but the additional impressions gathered through the observation sessions added to the information about these relationships. In all of the sessions that were observed, nurses were warm, caring, and focussed on the clients. In most of the sessions, the connection between the staff and the women was evident. These relationships appear to be an essential foundation on which to build practice. In one-on-one sessions in which the nurse seeing the client had not seen her previously, there was considerable effort to build on the work of the previous nurse, thus nurturing a relationship with the system if not with the individual. In the sessions in which more than one nurse was present and one of the nurses saw the clients individually while the other facilitated the group, relationships with both were evident. Community nurses relate to clients on many psychosocial levels. To accomplish this, "The art of nursing involves developing a sense of connectedness between clients, communities and the nurse that resonates a harmonic relationship" (Leonard, 2000, p. 93).

In commenting on relationships as part of public health nursing practice, Zerwekh (1991b) described two competencies that are an essential part of laying the groundwork for interactions with at-risk families: "This foundational phase of public health nurse family caregiving is brief and straightforward with stable families who are easy to locate, readily trusting, and sure of their own strengths" (p. 214). She went on to say that with more distressed families this is not the case. For these families "groundwork competencies assume a larger and larger proportion of nurse effort" and "building trust is foundational for all helping relationships, but it is a difficult proposition when not even

family or friends are trusted, much less human service professionals" (p. 215). The first competency that Zerwekh described is "locating" (p. 214). This is a concept that nurses identified in their responses to the survey. Nurses said they did "monthly telephone calls and home visits when possible to follow up with women who drop out of the program" (more than 10 years' experience, two years with the program). These fundamental functions of public health nursing are the most critical. If women disappear from the program and cannot be located or if they do not trust the individuals delivering the program, it is difficult to accomplish other positive outcomes.

The relationship is key and takes time to develop, especially when working with clients whose lives are complex. The essential relationships in the program are the relationships between the nurses and the women. "This relationship is reciprocal in that exchanges between help-seeker and help-giver evoke responses that can further strengthen or diminish the relationship" (Sword, 1999, p. 1174). When nurses respond that the first things they discuss are whatever issues the client brings up, they are speaking about initiating a relationship. Nurses use their relationship with women to make an assessment of those issues. They use their relationships within the health system and within the community to support women to connect with other resources to help them. These relationships are a part of the strategic process through which program delivery happens and through which outcomes are achieved.

"Studies have found that women who are satisfied with their care and view their health care providers as competent and concerned about their welfare are more likely to receive prenatal care" (Mikhail, 1999, p. 345). Because relationships may be quite personal and not every personality fits with every other one, it is often good to expose

women to a variety of nurses to improve the chances that they can find someone with whom they feel comfortable enough to discuss issues.

6.1.1.2 Nurses' Practice Context

The second part of relationship-based practice is the practice. Olds and Kitzman (1990) said, "Social support during pregnancy (without alteration of adverse behaviours) is not enough to improve birth weight and length of gestation" (p. 114). Although building relationships is *how* nurses work in Health for Two, the practice refers to *what* nurses are trying to accomplish. Part of the framework for this includes an examination and consideration of the context of the lives of women who participate in the program. The practice proceeds with an understanding of the context in which the women live. As depicted in Figure 1, when the context of nurses' practice overlaps with the context of women's lives, practice takes on a determinants of health perspective. This perspective influences the practice and will be discussed in more detail in a later section, but there are many other factors that influence nursing practice and, therefore, the perspective that practice takes in Health for Two.

The physical location of the program is one factor that relates to the concept of practice context. It is the visible context of the program, the actual setting where program activities are provided. During the observation phase of the study, the researcher had a chance to see a variety of settings and to form opinions about the way that those settings influence practice. When I began this research, I was of the opinion that the best way to deliver this program was in private meetings with individual clients. I also felt that having complete continuity of provider was an important element. By this I mean that the same client should see the same nurse every time she attends. Through this study I have

come to appreciate that if the program is to be responsive to the client, it is not always possible to provide continuity of provider. If it is important to the client to have this continuity, it should be arranged. If that is a driver for the client, she may arrange to come when the nurse is available. What is more important is that the client must feel comfortable accessing the service. To ensure that this is occurring, communication between staff members should be good, and there should be some standard elements to the program. If this happens it is more likely that a quality program will be delivered. It is this balance between responsiveness and efficient program delivery that must be obtained.

The environment in which the program is delivered is determined by a number of issues. In some communities there are very small numbers of women in the program. Even with active recruitment, the numbers would be small because of the socioeconomic situation in those communities. Providing a group session, although beneficial, is not possible in these circumstances. In other communities there are such a large number of women who are appropriate for the program that multiple delivery strategies need to be explored. "Studies of complimentary models of prenatal care for women of low income further support the notion that appropriate design and delivery of services is critical to enhanced utilization" (Sword, 1999, p. 1171).

When describing the strategies that they would use, more than half of the respondents (12/21) said that they would use one-on-one conversation. The same number (12/21) identified organizing group activities as a strategy that they would use. Where both were able to occur at the same time, it appeared to offer the most comprehensive package to the women. This allowed them to participate in the variety of group activities

available, but it also facilitated private discussions with one of the nursing staff. Clearly, the ability to provide this blend is dependent upon the number of women and the site.

Some sites have rooms available for Health for Two all of the time. This ensures that if women drop in at any time during the week, the visual aids and resources are available to them. In other sites, because they are not in the public health centre or they are in a multipurpose room, this type of resource must be put up and taken down for group sessions. This leads to fewer opportunities to use those aids to engage women.

Although it is extremely important to look at what clients want in programs, this researcher believes that to a large extent it is the professionals who are delivering the program who determine the way that it is delivered, and they are influenced by other issues in their practice setting. "Characteristics of health care agencies, including their priorities and philosophies of practice, determine program components and availability as well as how service providers deliver care" (Sword, 1999, p. 1174). Some of the issues that influence practice include the resources (including time) that they have at their disposal and their training and experience. In a program such as Health for Two, which is not a core program, nurses are also faced with competition from other programs for their time.

The experience that is required for this type of program is not just experience in community health nursing, but also experience with the target population. This was not a question that was specifically asked in the survey but would be something to address with nurses working in the program. Not all community health nurses have an opportunity to be exposed to a significant number of people who are living in poverty.

In her book *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, Patricia Benner (1984) described the difference between novice and expert practice:

> The expert rapidly grasps the problem by seeing it in relation to past similar and dissimilar situations and rapidly hones in on the correct region of the problem. The beginner, in contrast, must rely on detached, deliberate considerations of as many variables as possible. (p. 215)

Benner also stated that "for the individual lacking mastery, formal models can serve as a substitute for personal knowledge and experience," and "they are essential teaching guides, as they spell out what to do in situations in which the performer has had no prior experience" (p. 230).

Nurses need to have a better understanding of the structure of the program and the accountabilities they have in the program. Since Health for Two is not only delivered within the Capital Health system, the leadership and support for staff are not clearly understood by all. As one respondent put it in her response to what would make the program better, "A clear understanding of the line of command so to speak and clear guidelines of the role of each person involved in Health for Two" (5 to 10 years' nursing experience, more than three years delivering the program). This person was not a novice in nursing or in the program, and she lacked clarity about program accountability and leadership. Health for Two is not a core program and has no specific funding for the staffing part of the program. This, coupled with the fact that the target population is present in differing numbers in different communities, makes clarity difficult.

It is evident that although there are structured pieces available to nurses delivering the program, only a small number of respondents to the questionnaire noted that they would use the program binder as a guide (4/21), and fewer (2/21) stated that they would

use the care plan. In the observation sessions it was clear that content from the binder was used in educational sessions. Because the questionnaires were returned anonymously, it is not possible to identify whether those who responded that they would use the binders as a guide are the same ones who were observed to do so. In any case, there was no consistent indication that these tools were a prominent strategy in the minds of the respondents to the questionnaire.

After observing nurses in Health for Two at all public health centre sites and reading the responses to survey questions, it is clear to this researcher that nurses feel very connected to the program and the women who participate in it. In fact, they could be described as being passionate about the program. They are strong champions for the program at their own sites and strong advocates for the women, as well. It is through this strong advocacy that they try to make a difference for the women, but they also try to develop and obtain suitable resources to enhance program delivery.

What emerged from the data is that the nurses' ability to practice in this program is dependent upon their connection to and knowledge of other resources within and outside of the health system. Based on their relationships with these resources, nurses are able to help women to access additional support.

Nurses identified making referrals within the health system and in the community as a strategy they use with women. One nurse said that she would make "referrals to appropriate programs and services in Capital Health and the community" (5 to 10 years' experience, more than three years' experience with the program). Another nurse described this as "community linkages and intervention skills" (two to four years' experience, more than three years with the program). In fact, one nurse described the

program as a "touch point for entry to community health and partners for referral to identified support" (two to four years' experience, more than three years with the program). Building relationships with other community services was achieved through "interagency meetings with co-workers in the community and other health centres" (more than 10 years' experience, two years with the program). In meetings with other agencies nurses learn about resources that will be useful to their clients. By connecting with these resources, the nurses learn about the best way to help women to connect. In response to what would make the program better, nurses said "knowledge of resources," "more information about resources," and "close relationship with community partners-contacting for referrals, resources and information." Nurses with different levels of experience provided these answers.

Nowhere was the relationship to accessible resources and its value to the clients more evident than at the site in the women's health clinic. This clinic is located in a community health centre that provides a variety of other services including mental health, addictions counselling and treatment, and medical care in obstetrics and family practice. If a woman presents with an issue that would benefit from one of these services, that service is much more easily accessed. The nurse who is seeing the woman can call for help or even accompany the woman to the other practitioner. Having this kind of relationship with other resources makes it more likely that women will be able to follow through with accessing those resources. Maloni et al. (1996) concluded that "when multiple services were provided at one site, programs were more effective in enrolling and retaining clients from early pregnancy through the postpartum period" (p. 20).

Having access to these resources is a benefit for the learning of the nursing staff as well. If they go with the woman when she accesses the service, it is possible for the nurse to learn about the approach the other professional uses. This may enhance her ability to deal with women in the future. It certainly will improve the confident and knowledgeable way to make a referral in the future. Because it is important for women to have support when they are trying to change behaviours or deal with issues, access to resources that can provide that support is essential. Although this particular setting was a little more clinical in its appearance than some of the other sites, this access to resources makes it a valuable place for women to access programs in the prenatal and postnatal period. Connections to services that will be useful to them and their families at other times are more easily made.

During the observation sessions it was noticed that although there are similarities from site to site and common program elements, the program is delivered a little differently at each site. These differences may be related to the communities in which the health centres are situated. The differences may also relate to the number of women in the program at any given site as it reflects the number of women in the target population in that community. It may relate to the physical characteristics of the site itself.

Whatever the site of program delivery is, it creates the context for the program. Various sites offer different resources. Patton (1990) stated that context is critical to the evolution of a program. A variety of different sites were observed, and the context that was created in each one was slightly different. The availability of adjacent resources adds to the comprehensive nature of services delivered by the program. The practice of the nurses occurs within this context.

The structure of the program differed from site to site in terms of group and one-on-one sessions. This researcher found benefit in both delivery methods, and benefits were described by nurses in the surveys as well. As mentioned before, group sessions provide social support and interaction as well as opportunities to learn from other group members. One-on-one sessions provide direct contact with nursing staff and the opportunity to deal with more personal issues that women may feel uncomfortable discussing in group settings. The combination of both delivery methods seems to be the ideal.

During the observation phase of the study, nurses were asked whether they did home visiting as part of the program. Four nurses responded that they did. Most responded that they would like to do them. They felt that they would be particularly interested in visiting women who attended inconsistently to obtain a more comprehensive assessment of women who they felt were particularly at risk and to follow up with women who had dropped out of the program. These reasons fit with the expert competencies of community health nurses that were described by Zerwekh (1991b). The competencies that she described that fit with these reasons for home visits are *locating* and *persisting*. These refer to finding clients who have stopped coming to the program and doing home visits if they do not have telephones. Persisting is not giving up on clients. The persistence often leads to the women feeling valued, which may encourage them to participate in program activities. There was no indication from nursing staff that they would want this program to be exclusively a home-visiting program, but they would appreciate the opportunity to use home visiting as one strategy to use with women.

6.1.1.3 Woman's Life Context

Figure 1 identifies the woman as one key player in the program, and her life context is an important factor that is considered by nurses when program activities are planned and implemented.

As part of the Canada Prenatal Nutrition Program (CPNP), Health for Two is designed to meet the needs of those pregnant women most at risk for poor birth outcomes. These include "women living in poverty, teens, women who use alcohol, tobacco or other substances, women living in violent situations, Aboriginal women, recent immigrants and women living in social or geographic isolation or with limited access to services" (Health Canada, 1996, p. 2). Because this is a program targeted at pregnant women living in poverty, certain elements of their lives must be considered as part of program delivery. Reutter (1995) stated that

> empowering services should be offered in ways that respect the individual autonomy, are culturally sensitive, seek to understand the psychosocial and socioenvironmental contexts of the individual's concerns and problems, and move toward increasing the capacity of individuals to act upon both the symptoms and the roots of their distress. (p. 236)

Another aspect of the women's lives in this program is the relationships that had developed among the women in the groups. These relationships appeared to be another part of what attracts women to attend the program, what helps to sustain that attendance, and what increases the level of comfort women feel to ask about whatever concerns they have. There was a familiarity and a caring in certain circumstances that were clear indicators of social support. Women were overheard making plans with one another for activities outside of the program session. Because they are sharing the experience of pregnancy and are living with some similar life challenges, it may be possible for some

women to develop friendships that may provide more long lasting social support. In some cases, this was observed.

I was not convinced of the benefit of groups prior to this inquiry process, but the enthusiasm and warmth of the group settings made me a believer in their power as a strategy to engage and support women.

6.1.1.4 Determinants of Health

When asked what issues they discussed with women, the highest number of nurses responded that they would talk about nutrition (20/21). This is not surprising because Health for Two is part of the Canada Prenatal Nutrition Program. There are also a considerable number of resources, tools, and information about nutrition in pregnancy provided as part of the program material. When I was observing the program sessions, I had a chance to see several of the nutrition games that are part of program material. They appeared to work effectively to engage women in the issues surrounding nutrition and pregnancy.

The second most common issue identified was the issue of food security (12/21). This issue relates nutrition to the context of poverty and the Health for Two program material (Capital Health, 2000) explicitly encourages nurses to address food security with program participants. Nurses mentioned internal program resources such as milk coupons, bus tickets, and connection to other resources such as the food bank. Food was served and handed out at more than half of the sessions to assist women with this issue.

After these two topics, a number of pregnancy health and general health concerns were identified: labour and delivery preparation (11/21), prenatal care (10/21), growth and development (8/21), prenatal classes (7/21), and health issues (6/21). These issues

also are the safer ones for nurses to address with women. Nurses have training in these areas, but the Health for Two program resources and additional program training that is provided in these areas is also very extensive. That nursing staff used the resources available to them was noticed in the observation sessions.

Additional issues that nurses indicated that they addressed with women were "violence" (11/21), "social support" (10/21), "income" (7/21), "housing" (6/21), and "referral to resources" (8/21). Resources that they identified included "food banks and clothing banks" and "low cost, sliding scale programs for counselling and recreation." As one nurse put it, "Food and shelter are a priority." Only a small number of nurses identified substance abuse (4/21) and smoking (6/21) as issues that they would address with women.

The identification of these issues suggests that nurses in this program implicitly operate within a health determinants framework. As identified in Figure 1, the determinants of health are the point at which the women's life context intersects with the nurses' practice context. These determinants are a reality, part of the life context for the women, and if they are to be effectively addressed, they must be considered as part of the practice in this program. It is clear from the nurses' comments that they practice within this context; it is not as clear that they would explicitly describe it this way.

Health determinants are listed by Health Canada (1994) as "income and social status, social support networks, education, employment and working conditions, physical environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services" (p. 2). "Traditional prenatal care has focused on the detection of obstetric and medical problems. However, psychosocial

issues are increasingly being recognized as determinants of health for childbearing women and their families" (Reid et al., 1998, p. 677). "Experienced community health nurses have long understood that any health promotion efforts must be based within the broad socioeconomic contexts of people's local, regional, and even global issues and concerns" (Gottschalk & Baker, 2000, p. 3). Working within a context that considers all of these factors, although important, could be overwhelming if the nurse is not given permission to limit the issues that are addressed. In order to mitigate the effects of some of the social determinants, it is possible to work directly in certain areas.

As part of their assessment, nurses assist women to identify and develop social support networks. Half (10/21) of the nurses responded that one of the issues that they would address with women is social support. They referred to it in the following ways:

> What kind of relationships do they have—are they supportive? (5 to 10 years' experience, more than three years with the program)
>
> Talk about their general emotional well being and healthy relationships. (5 to 10 years' experience, more than three years with the program)
>
> Relationships and support. (5 to 10 years' experience, more than three years with the program)
>
> Checking her support system—partner, family, friends; what are these relationships like for her. Are they supportive, abusive, unhealthy? . . . [and] "a mother with good support can get through just about anything. (more than 10 years' experience, more than three years with the program)
>
> Sometimes you have to ask directly—is there a father involved—how does he feel about the pregnancy—has his behaviour changed? (5 to 10 years' experience, more than three years with the program)

From these quotations it is clear that nurses consider and address the issues of social support with women and use a variety of questions to gain their understanding of the women's situations in this area.

Violence is a prime example of how nurses address the social support (or lack of it) in the Health for Two program. Although violence is a difficult issue to address with women, "research has shown that prenatal care provides a window of opportunity to implement abuse protocols in public health clinics. Abuse assessment, referral, and documentation should be a routine part of maternity care" (Wiist & McFarlane, 1999, p. 1220). In this study, more than half (11/21) of the nurses said that they would discuss violence with women. However, most (9/11) of the nurses who responded that they would discuss violence had between 5 and 10 years experience. This may indicate that nurses with more nursing experience feel more comfortable discussing this type of issue. There is no specific abuse protocol identified as part of Health for Two or of community health services in general.

> An intervention protocol for abused pregnant women that included specific information on safety behaviours resulted in a significant increase in the adoption of these behaviours. Most of the safety behaviours were adopted after the first intervention session. Routine screening for abuse and immediate implementation of a clinical intervention can possibly prevent future abuse and associated complications for mother and child. (McFarlane, Parker, Soeken, Silva, & Reel, 1997, p. 68).

Such a protocol may have a huge relevance and impact on Health for Two, by supporting nurses' practice in addressing women's life context. Nurses assist women to enhance personal health practices and coping skills. Nurses with various amounts of experience described this. Some quotations that illustrate this are as follows:

> Coping skills and issues regarding income and social assistance. (5 to 10 years' experience, more than one year with the program)
>
> Balance in their lives, physical health, spiritual health, recognizing imbalance and making changes in life to address this. (more than 10 years' experience, one year with the program)

> Subjective client evaluation of physical and emotional well being. (two to four years' experience, more than three years with the program)

"Most women want to care for themselves when they are pregnant. But some will need help to change behaviours such as smoking and substance abuse, to improve their nutrition, and to cope with stressful lives" (Moore & Freda, 1998, p. 203). Only a small number of nurses identified substance abuse (4/21) and smoking (6/21) as issues that they would address with women. Selleck and Redding (1997) demonstrated that

> pregnancy presents a window of opportunity for motivating women to stop their abuse of substances. To do so, however, nurses must be armed with the knowledge and information necessary to screen and identify women who abuse substances while pregnant. They also must maintain a nonjudgmental, nonpunitive attitude. It is with this knowledge and understanding that nurses are most likely to exhibit positive behaviours and attitudes while they provide support for women who are in need of substance abuse treatment. (p. 76)

In order for nurses to work effectively in these areas, they need knowledge about the issues and the correct attitude. This idea was supported by survey results "trying to provide a non-judgmental environment and giving them confidence that they know what is best for them and keep encouraging them" (more than 10 years' experience, more than three years with the program). This statement was a goal, but the same nurse identified that "building a relationship or getting to know the woman and what is going on in her life" is a strategy. Nurses deliver service using the knowledge they have acquired about issues though education and experience. This knowledge affects their attitude toward clients who are experiencing these issues. Substance abuse is an example of this. Selleck and Redding (1998) found that greater knowledge about the subject was positively related to more positive attitudes. This supports the idea that nurses will require training to deal with these more difficult kinds of issues. Although the Health for Two program materials

provides useful tools to deal with the issues of nutrition, pregnancy health, and labour and delivery, there are less information and relatively few tools to assist nurses to deal with issues such as family violence, substance use, and smoking. The literature stressed that pregnancy is an excellent time to deal with these issues but that nurses need training and structure to feel confident to do this. Once again, the connection to nurses' practice context becomes clear.

Nurses made the connection between a healthy pregnancy and healthy child development and provided resources to assist women with positive parenting:

> I talk about growth and development of the baby and a healthy pregnancy. (less than two years' experience, one year with the program)
>
> Development of the fetus in utero, what to ask at the doctor's visit, nutrition for a healthy pregnancy, healthy infant, healthy family. (more than 10 years' experience, two years with the program).

Finally, nurses provide an excellent connection to health services for these women and their families. Not only do they understand the services available through the public health system, but they are also aware of other health and community resources. Throughout the research process, nursing staff (8/21) identified the use of other resources in the community and in the health system or even right on the site as a strategy that they would use.

6.1.1.5 The Interconnections among Women's Lives, Nurses' Practice and Determinants of Health through Relationships

Besner (1999) believed that "public health nursing's focus should be on helping people assume control and mastery over their lives, through the provision of needed skills, knowledge and other resources in a supportive, non-controlling manner" (p. 33). Nurses reflected these ideas in their responses to the questionnaire. They said that they

wanted to "provide women with options—empowerment to affect change in their lives" and "provide support to assist mom to make healthy decisions." This identified what they wanted to achieve, and other comments described the atmosphere in which they wanted to achieve it.

Although the relationship-based practice of nurses in the Health for Two program was pictured in the model as a series of distinct components, this was done in a purely illustrative way to emphasize the unique contributions of the various components. However, as it is pictured, it is clear that there is overlap between the various parts of the model. In practice, the work of nurses in the program, while delivered with an understanding of the determinants of health framework is fluid and responsive. The life context of the woman is in a constant state of flux as well. Each interaction may be influenced by circumstances that were not present in the previous one. It is the relationship between the woman and the nurse at the core of the program that creates a mechanism to identify and respond to these changes.

6.2 Recommendations

Health for Two is not a core program in Capital Health, even though it is delivered in each site. This explains the variation in program delivery methods. It is not a universal program because the target population for the program exists in varying numbers throughout the region. Another variable is the experience and knowledge of the nursing staff involved. There is a great deal of program material that is being used in various ways around the region. It would be important to ensure that this material is being used consistently so that all issues are being addressed with women in this priority group.

Nursing staff must have a way to gain experience working with the target population. Exchange of staff across health centres to areas where there is a larger number of the target population would be an excellent idea and fairly easy to facilitate.

As was mentioned in the observation results, some of the sites keep women in the program until their babies are one year old. The mandate of the program is to offer it to women prenatally and until the baby is two months of age. Although having women with the program for a longer time cements the relationships they have with nursing staff and with each other, the presence of older babies and toddlers is distracting. It may also be discouraging for newly pregnant women who come to group sessions. This is not to discount the fact that women need support with their babies after they are two months of age. Often standard programs for new mothers are neither appealing nor useful for this group of women. As with Health for Two, these women need a parent support group that considers their life circumstances. It would be important to identify existing programs in the community or, in the absence of such programs, to develop one. If such a program existed, it would be a natural point of discussion and referral from Health for Two and would allow women to move with the support networks they had developed. This would make transition easier for the women and for the nursing staff.

This type of program would provide a perfect opportunity for peer mentoring. Several nurses identified a desire to have a training program for women who showed leadership skills in Health for Two. Peer mentoring is a way to enhance the *women's life context*, as depicted in Figure 1. Providing training and experience for women may enhance their ability to seek employment in the future. This would be an additional benefit of the program for the women one that could potentially have long lasting effect.

This type of training may also be one way to enhance the human resources of the program, but it would require the involvement of the volunteer coordinator. Other programs in the system use this model to assist with program delivery.

Many nurses commented that they wished that they could have more time with women. In order to increase time spent with women during pregnancy and early prenatal period, it would be important to look at moving women on to other resources after two months to free up time to bring other women into the program.

Dealing with issues such as smoking, substance use, and violence requires skilled screening and intervention supported by knowledge of and access to community resources that are suitable. Nurses must be provided with this training and screening tools to work effectively with women on these modifiable risk factors.

It is apparent that nurses in Health for Two work in a framework that considers the determinants of health. This context needs to be made explicit, and nurses need to be given a sense of how that impacts the work that they do. If they become overwhelmed by the life circumstances of these women, they will become frustrated. They need to be given permission to work in specific areas where they may be able to make a difference and refer women to other resources to enhance their ability to provide a more comprehensive program for them.

Nursing has shifted from a generalist role to a more focussed practice in the area of community health. This may create an environment where nurses delivering a specific program like Health for Two are less likely to see the "big picture" in the community. They may be more focussed on delivery of service to the clients already in the program and have less ownership of the issue of identifying clients who are not attending the

program but may benefit from it. A process must be put in place for recruitment of women to the program who may not get there on their own.

Health Promotion programs like Health for Two are frequently delivered in a multidisciplinary environment. While this is a very important way to work, it is also important for each discipline to analyze the specific nature of their unique contribution. Looking at the practice of nurses in this program may help to identify ways to maximize their contribution to the team. It may be equally valuable to study the practice of other professionals for this same reason.

In summary, "There is a widespread agreement that prenatal care is necessary for the health and well-being of women and children. Birth outcomes are determined, to a large extent, by maternal health during the prenatal period" (Mikhail, 1999, p. 335). The way in which that prenatal care is delivered by nurses to women whose life contexts are challenging at best, and insights into how services can be improved, is the domain of this thesis.

References

Alreck, P., & Settle, R. (1995). *The survey research handbook* (2nd ed.). Madison: Irwin Professional.

Anderson, E., & McFarlane, J. (2000). *Community as partner: Theory and practice in nursing* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park: Addison Wesley.

Besner, J. (1999). *A theory-based approach to establishing effectiveness in a public health nursing program.* Unpublished master's thesis, University of Alberta, Edmonton, Alberta, Canada.

Capital Health. (1999). *Health for Two: Program delivery manual.* Edmonton, AB: Author.

Capital Health. (2000). Health for Two: Evaluation and needs assessment. (Prepared by MacLean Management.) Edmonton, AB: Author.

Capital Health Authority. (1995). *Health for Two: Program development and review.* Edmonton, AB: Author.

Capital Health, Community Health Services. (2000). *Health for Two care plan.* Edmonton, AB: Author.

Capital Health, Regional Public Health. (1997). *How healthy are we? Health status in the Capital Health Region.* Edmonton, AB: Author.

Clark, M. (1999). *Community health nursing handbook.* Stamford: Appleton and Lange.

Childbirth Graphics. (1995). *With Child.* Elora, ON: Author.

Deal, L. (1994). The effectiveness of community health nursing interventions: A literature review. *Public Health Nursing, 11*(5), 315-323.

Dunn, C., Pirie, P., & Lando, H. (1998). Attitudes and perception related to smoking among pregnant and postpartum women in a low-income, multiethnic setting. *American Journal of Health Promotion, 12*(4), 267-274.

Epp, J. (1986). Achieving health for all: A framework for health promotion. *Canadian Journal of Public Health, 77*(6), 393-430.

Ershoff, D., Mullen, P., & Quinn, V. (1989). A randomized trial of a serialized self-help smoking cessation program for pregnant women in an HMO. *American Journal of Public Health, 79*(2), 182-187.

Gazmararian, J., Adams, M., & Pamuk, E. (1996). Associations between measures of socioeconomic status and maternal health behavior. *American Journal of Preventive Medicine, 12*(2), 108-115.

Gottschalk, J., & Baker, S. (2000). Primary health care. In E.T. Anderson & J. McFarlane (Eds.), *Community as partner: Theory and practice in nursing* (pp.3-23). Philadelphia: Lippincott Williams Wilkins.

Groff J., Mullen, P., Mongoven, M., & Burau, K. (1997). Prenatal weight gain patterns and infant birthweight associated with maternal smoking. *BIRTH, 24*(4), 234-239.

Health Canada. (1994). *Canada prenatal nutrition program: Guide for applicants, Alberta.* Ottawa: Author.

Health Canada Communication and Consultation Directorate. (1996). *Report on the health of Canadians.* Ottawa: Author.

Health Canada Communications Directorate. (1994). *Strategies for population health: Investing in the health of Canadians.* Ottawa: Author.

Hertzman, C. (1998). The case for child development as a determinant of health. *Canadian Journal of Public Health, 89*(Supplement), S14-S18.

Horne, T. (1996). *Tobacco, alcohol and drug use during pregnancy.* Edmonton, AB: Capital Health Authority.

Johnson, T., Drisko, J., Gallagher, K., & Barela, C. (1999). Low birth weight: A women's health issue. *Women's Health Issues, 9*(5), 223-230.

Kearney, M., Murphy, S., Irwin, K., & Rosenbaum, M. (1995). Salvaging self: A grounded theory of pregnancy on crack cocaine. *Nursing Research, 44*(4), 208-213.

King, M., Harrison, M., & Reutter, L. (1995). Public health nursing or community health nursing: What's in a name? In M. Stewart (Ed.) *Community nursing: Promoting Canadian's health.* Toronto: W. B. Saunders.

Kistin, N., Abramson, R., & Dublin, P. (1994). Effect of peer counselors on breastfeeding initiation, exclusivity, and duration among low-income urban women. *Journal of Human Lactation, 10*(1), 11-15.

Kitzman, H., Olds, D., Henderson, C., Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K., Sidora, K., Luckey, D., Shaver, D., Engelhardt, K., James, D., & Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. *JAMA, 278*(8), 644-652.

Lalonde, M. (1974). *A new perspective on the health of Canadians: A working document.* Ottawa: Health and Welfare Canada.

Lapierre, J., Perreault, M., & Goulet, C. (1995). Prenatal peer counseling: an answer to the persistent difficulties with prenatal care for low-income women. *Public Health Nursing, 12*(1), 53-60.

Leonard, B. (2000). Community empowerment and healing. In E. T. Anderson & J. McFarlane (Eds.), *Community as partner: Theory and practice in nursing* (pp. 92-113). Philadelphia: Lippincott Williams & Wilkins.

Lieberman, L. (1998). Overview of substance abuse prevention and treatment approaches in urban, multicultural settings: The Center for Substance Abuse Prevention Programs for pregnant and postpartum women and their infants. *Women's Health Issues, 8*(4), 206-217.

Maloni, J., Cheng, C., Liebl, C., & Maier, J. (1996). Transforming prenatal care: Reflections on the past and present with implications for the future. *JOGNN, 25*(1), 17-23.

Marshall, C., & Rossman, G. (1995). *Designing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Marshall, R. (2000). The best health care. *Maclean's, 113*(32), 18-32.

McCormick, M., Brooks-Gunn, J., Shorter, T., Holmes, J., Wallace, C., & Heagarty, M. (1990). Factors associated with smoking in low-birthweight, stressful life events, social support, health behaviors and mental distress. *Journal of Clinical Epidemiology, 43*(5), 441-448.

McFarlane, J., & Fehir, J. (1994). *De Madres a Madres*: A community primary health care program based on empowerment. *Health Education Quarterly, 21*(3), 381-394.

McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reel, S. (1998). Safety behaviours of abused women after an intervention during pregnancy. *JOGNN, 27*(1), 64-69.

Merkatz, I., & Thompson, J. (1990). *New perspectives on prenatal care.* New York: Elsevier.

Mikhail, B. (1999). Perceived impediments to prenatal care among low-income women. *Western Journal of Nursing Research, 21*(3), 335-355.

Miles, M., & Huberman, A. (1994). *Qualitative data analysis: an expanded sourcebook.* Thousand Oaks, CA: Sage.

Moore, M., & Freda, M. (1998). Reducing preterm and low birthweight births: Still a nursing challenge. *MCN, 23*(4), 200-208.

Moore, M., Zaccaro, D., & Parsons, L. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *JOGNN, 27*(2), 175-182.

Morgan, A. (1994). Client education experiences in professional nursing practice: A phenomenological perspective. *Journal of Advanced Nursing, 19*, 792-801.

National Forum on Health (1997). Determinants of health working group synthesis report. *Canada Health Action: Building on the Legacy.* Ottawa: Author.

O'Connor, A., Davies, B., Dulberg, C., Buhler, P., Nadon, C., McBride, B., & Benzie, R. (1992). Effectiveness of a pregnancy smoking cessation program. *JOGNN, 21*(5), 385-392.

Oermann, M. (1991). *Professional nursing practice: a conceptual approach.* Philadelphia: J.B. Lippincott Company.

O'Keefe, E. (1995). Values and ethical issues. In S. Pike & D. Forster (Eds.), *Health Promotion for All* (pp. 55-65). New York: Churchill Livingstone.

Olds, D. (1992). Home visitation for pregnant women and parents of young children. *AJDC, 146*, 704-708.

Olds, D., & Kitzman, H. (1990). Can home visitation improve the health of women and children at environmental risk? *Pediatrics, 86*(1), 108-116.

Overbo, B., Ryan, M., Jackson, K., & Hutchinson, K. (1994). The homeless prenatal program: A model for empowering homeless pregnant women. *Health Education Quarterly, 21*(2), 187-198.

Parker, B., McFarlane, J., Soeken, K., Silva, C., & Reel, S. (1999). Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing and Health, 22*, 59-66.

Patton, M. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA.: Sage.

Prochaska, J., & DiClemente, C. (1992). Stages of change in the modification of problem behaviours. In M. Hersen, R. M. Eisler, & P. M. Miller (Eds.), *Progress in behaviour modification* (pp. 184-214). Sycamore, IL: Sycamore Press.

Reid, A., Biringer, A., Carroll, J., Midmer, D., Wilson, L., Chalmers, B., & Stewart, D. (1998). Using the ALPHA form in practice to assess antenatal psychosocial health. *CMAJ, 159*(6), 677-684.

Renker, P. (1999). Physical abuse, social support, self-care, and pregnancy outcomes of older adolescents. *JOGNN, 28(*4), 377-388.

Reutter, L., & Ford, J. (1998). Perceptions of changes in public health nursing practice: A Canadian perspective. *International Journal of Nursing Studies, 35*, 85-94.

Richardson, K. (1999). Adolescent pregnancy and substance use. *JOGNN, 28*(6), 623-627.

Rossman, G., & Rallis, S. (1998). *Learning in the field: an introduction to qualitative research.* Thousand Oaks: Sage.

Selleck, C., & Redding, B. (1998). Knowledge and attitudes of registered nurses toward perinatal substance abuse. *JOGNN, 27*(1), 70-77.

Shepard, M., Elliott, B., Falk, D, & Regal, R. (1999). Public health nurses' responses to domestic violence: A report from the enhanced domestic abuse intervention program. *Public Health Nursing, 16*(5), 359-366.

Stewart, M. J. (Ed.). (1995). *Community nursing: Promoting Canadians' health.* Toronto: W. B. Saunders.

Stewart, M., Brosky, G., Gillis, A., Jackson, S., Johnston, G., Kirkland, S., Leigh, G., Pawliw-Fry, B., Peraud, V., & Rootman, I. (1996). Disadvantaged women and smoking. *Canadian Journal of Public Health, 87*(4), 257-260.

Stotts, A., DiClemente, C., Carbonari, J., & Mullen, P. (1996). Pregnancy, smoking cessation: A case of mistaken identity. *Addictive Behaviors, 21*(4), 459-471.

Sword, W. (1999). A socio-ecological approach to understanding barriers to prenatal care for women of low income. *Journal of Advanced Nursing, 29*(5), 1170-1177.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion, 6*(3), 197-205.

Whitehead, M. (1995). Tackling inequalities: a review of policy initiatives. In M. Benzeval, K. Judge, & M. Whitehead (Eds.), *Tackling Inequalities in Health: An agenda for action* (pp. 22-52). London: King's Fund.

Wiist, W., & McFarlane, J. (1999). The effectiveness of an abuse assessment protocol in public health prenatal clinics. *American Journal of Public Health, 89*(8), 1217-1221

Williamson, D., & Reutter, L. (1999). Defining and measuring poverty: implications for the health of Canadians. *Health Promotion International, 14*(4), 355-364.

Windsor, R., Lowe, J., Perkins, L., Smith-Yoder, D., Artz, L., Crawford, Amburgy, K., & Boyd, N. (1993). Health education for pregnant smokers: Its behavioral impact and cost benefit. *American Journal of Public Health, 83*(2), 201-206.

Woodard, G., & Edouard, L. (1992). Reaching out: A community initiative for disadvantaged pregnant women. *Canadian Journal of Public Health, 83*(3), 188-190.

Zerwekh, J. (1991a). At the expense of their souls. *Nursing Outlook, 39*(2), 58-61.

Zerwekh, J. (1991b). A family caregiving model for public health nursing. *Nursing Outlook, 39*(5), 213-217.

Zerwekh, J. (1992a). Laying the groundwork for family self-help: Locating families, building trust, and building strength. *Public Health Nursing, 9(*1), 15-21.

Zerwekh, J. (1992b). The practice of empowerment and coercion by expert public nurses. *IMAGE: Journal of Nursing Scholarship, 24*(2), 101-105.

Appendix A

Observation Guide

Setting

Human or social environment

Planned program

Informal interactions

Language of the program

Comments

Appendix B

Background Information Form

and Survey Questionnaire

1. Years of experience in community health nursing:

   _____ 0-2

   _____ 2-4

   _____5-10

   _____More than 10

2. Length of time delivering Health for Two:

   _____1 year

   _____2 years

   _____3 years or more

3. How often do you deliver the Health for Two program?

   _____Once per week

   _____Twice per week

   _____More that twice per week

Survey for Nursing Staff Delivering Health for Two

Please fill the survey out in point form:

1. What issues do you address with women who are clients of the Health for Two program?

2. What are you trying to achieve when you are delivering the Health for Two program?

3. What strategies do you use when delivering the Health for Two program? (How do you do what you want to do?)

4. How do you know if you have been successful?

5. What would help you to deliver a more comprehensive program to women in the Health for Two program?

Appendix C

Information Letter and Consent Form

Name of Project:
Community Health Nursing Practice in the Delivery of the Health for Two Program.

Investigator:
Dawn Wrightson, BScN, MSc Candidate,
Centre for Health Promotion Studies, University of Alberta 458-7896

Supervisor:
Kim Raine-Travers, PhD, RD, Associate Professor,
Centre for Health Promotion Studies, University of Alberta

Purpose of the Project:
Health for Two is delivered at all of the public health centres. Because there was no specific budget allocation for program staff when it started, staff has been allocated from each health centre as resources permitted. This has resulted in different delivery methods at various sites. The purpose of this study is to:

- examine and document the practice of community health nurses delivering Health for Two at all sites in Capital Health
- identify consistent or responsively inconsistent practice patterns of community health nurses delivering this program
- identify possible directions for future improvement of the program

Background:
Health for Two is a health promotion program for pregnant women and new mothers living in disadvantaged economic and social conditions. The program is designed to influence factors that determine health, by supporting these women, by increasing their knowledge of pregnancy, birth and childcare and by providing opportunities to improve their nutrition. The program started in 1992 in the inner city as a collaborative partnership between six inner city agencies and the Edmonton Board of Health. Since that time the program has grown to include 37 agencies and 12 public health centres in the Capital Health Region in over 50 different delivery sites. A recent program evaluation suggested that it might be important to increase the number of nurses supporting the program.

Procedures:
The first phase of this study will include observation of Health for Two sessions at each public health centre throughout the region. Notes will be made at each session. These will be transcribed and then circulated to individuals who are delivering the program so they can be reviewed to ensure accuracy of reporting.
The second phase of the study will involve a questionnaire to be administered to each of the community health nurses who deliver Health for Two. Participation in the survey is voluntary and confidentiality of responses will be protected. Aggregate data only will be presented after the results of the survey and observation sessions are collated.

Participation in the survey by as many nurses as possible will improve the accuracy of the data. It is hoped that this information will help to determine how to proceed if additional resources become available for this program.

Benefits:

- Perspective of Health for Two program delivery from across all Capital Health public health centres will be documented
- Information to assist with future planning and improved program support

Risks:

- There are no known risks to participation.
- The time involved in completing the survey may be an inconvenience.

Confidentiality:

This study is being done for a Master's thesis. All information provided (questionnaires and observations) will be kept confidential. As per University policy, all data will be kept coded by subject, locked in file drawer, and kept for seven years. The information will be made into a report but results will not identify any participant by name.

Your decision to participate in this questionnaire is voluntary. You have a right to refuse to answer any question. You are free to withdraw your participation at any time, with no threat to your employments.